

DOMESTIC VIOLENCE FATALITIES:
A preventable crime?

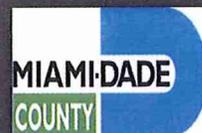
Miami-Dade County Domestic Violence

FATALITY REVIEW TEAM

Comprehensive Report, 1997-2005

a report dedicated to
understanding and preventing

DOMESTIC HOMICIDE.



MIAMI-DADE COUNTY DOMESTIC VIOLENCE

FATALITY REVIEW TEAM

PREFACE

ACKNOWLEDGMENTS

Miami-Dade County's Domestic Violence Fatality Review Team could not have been developed and operate at the level of excellence and innovation as it has since its inception in May of 1998 without the dedication of many esteemed professionals in their individual disciplines. In particular, those that have served on the Research Committees for both adult fatalities and child deaths due to abuse and neglect deserve special thanks for their commitment to this endeavor and that of learning from the personal tragedies that are studied with the purpose of closing system gaps to prevent further lethal incidents. We are truly grateful for the insight, expertise, wisdom, and support of the current and former Review Team Members listed below.

In addition, we are extremely grateful for the commitment of the community leaders who have served with distinction as members of our Advisory Panel, and whose role it is to facilitate support and access to achieve development of policies and protocols for community prevention and intervention strategies geared towards violence reduction.

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*We would like to express special recognition and appreciation to **Silvia Cerezo McShan, M.P.A.**, our original Review Team Coordinator, and her successor, **Isabel Perez-Morina, Ph.D.**, who continually strived to achieve excellence in every aspect of their work coordinating the operations of the Review Team, and were integral to the successful advancements achieved once funding had been obtained. We would also like to express our appreciation to **Phillip Rogers**, former Administrative Assistant, Domestic Violence Division, whose unwavering administrative support, prior to funding being obtained, was enormously helpful.*

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*We would like to especially recognize **Kathryn Gutstein**, who, as the original Co-Vice Chair of the Review Team, dedicated herself to all aspects of the Review Team's successful formation. We would also like to particularly express our eternal gratitude to **Michael Lindsey**, our other original Co-Vice Chair, whose passion, vision, and drive to confront and overcome the formidable obstacles which stand in the way of eradicating domestic violence, and lethal violence in particular, served as the fundamental force which caused others to take notice of the realism and severity involved with this issue, and the need to use fatality review as a mechanism to look at the system with a lens of preventive accountability. In addition, we would like to express our thanks to **Dwight Danie**, former GIS Administrator, Community*

Services Planning Center of South Florida, Florida Department of Children & Families, whose innovative work was integral to ensuring that our data was depicted on an innovative, countywide, geographic basis, by Commission District, for the first time in the country.

Isabel Perez-Morina, Ph.D., initially contracted with the Miami-Dade County Domestic Violence Fatality Review Team as a consultant, in the capacity as the primary author of the *Miami-Dade County Domestic Violence Fatality Review Team's Comprehensive Report*. **Adrienne Celaya, M.A.**, carried on Dr. Perez-Morina's work as contributing author and final editor.

The creative vision and graphic design for the cover of this report is the work of **Natalie Billini**.

*Miami-Dade County's Domestic Violence Fatality Review Team would like to also acknowledge the significant contribution **Robin Hassler Thompson, J.D.**, made with regard to instituting this initiative on a statewide basis in her former capacity as Executive Director of the Governor's Task Force on Domestic Violence, as well as **Byron Johnson, Ph.D.**, and particularly, **Neil Websdale, Ph.D.**, who served as the inspiration, impetus, and a true mentor for the Chair of the Review Team, and whose expertise in the select area of domestic homicide and accompanying unwavering commitment to ensuring that communities nationwide recognize the significant impact fatality reviews may have on reducing the homicide rate, is unparalleled.*

*In addition, we would like to extend our appreciation and special thanks to **Jennifer Dritt**, Former Domestic Violence Program Analyst, Domestic Violence Unit, Office of Family Safety, Florida Department of Children and Families, for her efforts to further statewide coordination on fatality review issues, as well as her predecessors, **Deborah Kleinman Robinson** and **Sondra Williams**, and FDLE's Former Domestic Violence Fatality Review Resource Center Supervisor, **Randy Luttrell**, **Nikki Kight** and **Janice Henderson**, Former Government Analysts, and staff.*

*We would also like to pay special tribute to the late **Denise Moon**, Victim Witness Supervisor, State Attorney's Office, whose contributions and passion for victims of violent crime still resound with all of us today.*

MIAMI-DADE COUNTY DOMESTIC VIOLENCE

FATALITY REVIEW TEAM

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MIAMI-DADE COUNTY DOMESTIC VIOLENCE

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SECTION 1

EXECUTIVE SUMMARY

On average, fifteen percent of all homicide and suicide deaths in Miami-Dade County are domestic violence-related. Between the years 1999-2005, there were a total of 464 domestic violence-related *deaths* and 377 domestic violence-related *incidents* in Miami-Dade County. Fifty-seven percent of the homicide deaths for these years were intimate partner-related. The majority, or eighty percent, of these decedents were females. The killing of a sexual competitor, characterized by the death of the former or present lover of the perpetrator's current or former intimate partner, were incidents exclusive to male perpetrators. For these types of incidents, and intimate partner domestic homicide, the most prevalent cause of death was by gunshot wound. For homicides that were family-related and did *not* involve children, the main cause of death was by gunshot wound as well.

Of the 377 domestic violence-related *incidents*, 62 of these were homicide/suicide incidents. The amount of deaths relating to these incidents was 134. Three of these incidents were perpetrated by women. Of all the 377 domestic violence-related *incidents*, 18 incidents involved the multiple killing of victims. These resulted in 50 fatalities, of which 14 were minor children. Seventeen of these incidents were perpetrated by men, and 56% involved an intimate partner decedent, all of which were female.

For the years 1999-2005, there were a total of 124 domestic violence-related suicides. Eighty-seven percent of these perpetrators were males. Age appeared to be a variable with respect to these deaths, that is, younger males were more likely to commit suicide, but for females the differences in the age groups were less pronounced. The majority of these deaths were committed using a firearm.

The Miami-Dade Domestic Violence Fatality Review Team reviewed a total of 119 cases by the conclusion of 2005. The total number of decedents involved, not including perpetrators who committed suicide, was 136. Of the 119 cases, 112 were intimate partner-related. Of these, 102 involved male perpetrators, of which 56 committed suicide. Ten of the intimate partner-related homicides involved female perpetrators, one of which committed suicide.

For those intimate partner-related homicides, where a male was the perpetrator of a *single* killing, 36% were separated at the time of the fatal incident. Of these, a major portion, or 67% percent, were separated for less than six months. For those involving *multiple* killings, 36% of the parties had been separated at the time of the fatal incident, all of which had been separated for less than six months.

Eighty-four percent of the victims of *single* killings by male perpetrators were between the ages of 18-49. The majority, or 35%, of these were between the ages of 30-39. Eighty percent of the perpetrators were between the ages of 18-49, and the majority, or 33%, of these were between the ages of 30-39. The cause of death for 60% of these homicides was a gunshot wound. For those incidents involving *multiple* killings, all but one were caused by gunshot wounds.

Sixty-nine percent of these *single* killings were committed at the decedent's own residence. In almost one-fifth of these cases, children witnessed the homicide, either visually or by earshot. Thirty-eight percent of these cases revealed at least one prior domestic violence police report. Fifty-four percent revealed prior domestic violence reports to friends and/or family members. For the incidents involving *multiple* killings, 36% had at least one prior domestic violence police report and 45% revealed prior domestic violence reports to friends and/or family members. In a very small percentage of these cases, the victim sought injunctive relief.

Thirty-four percent of the *single* killing cases that were reviewed involving male perpetrators revealed a history of stalking, while 45% of the *multiple* killing cases that were reviewed involved a history of stalking. In both single and multiple killing incidents, the most prevalent lethality indicators were those

that demonstrated an ownership/centrality of the victim to the perpetrator. Other prevalent lethality indicators included antisocial behavior and decompensation. For those perpetrators who committed suicide at the time of the fatal incident, 54% were under the influence of alcohol and/or drugs at the time of the offense.

The reviews revealed that gunshot wounds were the cause of death for the majority of domestic homicides. One of our initial findings was that in many of these cases, allegations of domestic violence were made to family and/or friends. However, there was an under-utilization of agencies that could intervene, such as injunctive or shelter services. Victims need further information about the availability of assistance and should be encouraged by family and friends to access these support services. Further, educational awareness of death threats should be a training topic to focus upon throughout the community as well as service providers.

Risk management practices (assessment and communication) of all involved agencies have not been institutionalized to the extent necessary to provide for victim safety. A clear finding is that separation from the relationship increases risk for domestic homicide. The effect of an injunction and divorce being sought by the victim may be viewed as aggravating factors which result in the escalation of violence, and thus safety planning, such as limiting the access to victim and/or children, may be critical.

One of the Review Team's most alarming findings is the significant number of children who become exposed to domestic homicide. In approximately one-third of these cases, children witnessed the homicide either visually or by earshot. The reviews also revealed the fact that the Medical Examiner's Office does not currently have staff available to provide support and social service intervention with grieving families, which would be beneficial to the community.

Outside of the efforts of the Review Team, no mechanism existed to collect uniform, reliable statistics as to the number of domestic violence-related deaths (homicides and suicides) occurring annually on a countywide basis. The data collection methods used by law enforcement vary widely between agencies and are inconsistent in terms of how case is identified as being domestic violence-related. In addition, no network of communication existed between the respective agencies. Gratefully, many of these findings of "system gaps" were acted upon by the administrations of the respective agencies. This system response has been critical to our mission to prevent domestic fatalities.

MIAMI-DADE COUNTY DOMESTIC VIOLENCE

FATALITY REVIEW TEAM

SECTION 2

CREATION & EVOLUTION OF THE FATALITY REVIEW PROCESS

In May of 1998, the Florida Governor's Task Force on Domestic Violence chose four jurisdictions to lead the way in a landmark initiative, "Implementing Fatality Review Teams in Florida." With funding through the Violence Against Women Grants Office of the U.S. Department of Justice, this initiative was designed to reduce domestic violence in general, and lethal violence in particular. The four sites chosen to participate were Miami-Dade County, Tampa/Hillsborough Counties, Palm Beach County, and Volusia/Putnam Counties.

The Fatality Review Teams were created to bring together professionals from diverse agencies and backgrounds in an effort to review adult and child domestic violence-related fatalities with a view towards identifying how these tragedies might have been prevented. In order for the Review Team to carry out its functions effectively, the designated Chair and Vice-Chairs invited the participation of representatives of key community agencies from multiple disciplines, which regularly intervene in family violence cases, including the time after which a homicide occurs. These agencies included, but are not limited to: the local Alliance Against Domestic Violence, Batterers' Intervention Programs, Child Protection Programs, Court Administration, Department of Children and Families, Domestic Violence Oversight Board, Miami-Dade County Public Schools, Victim Response Inc., Advocates for Victims Program, legal services, Humane Society, immigrant rights programs, law enforcement, Medical Examiner's Office, Probation Department, public health/medical community, related community social service programs, religious community, and the State Attorney's Office. Through its Advisory Panel, Miami-Dade County's Review Team has offered community prevention and intervention strategies based on the knowledge gained from the review process. The Review Team consists of approximately fifty-eight members, with additional members on its Advisory Panel, which is instrumental to facilitating support and access to achieving the development of prevention strategies.

Miami-Dade's Fatality Review Team began meeting monthly in June of 1998. At the first two meetings, members of the Governor's Task Force were in attendance to provide technical assistance, including the authors of the 1994 Florida Mortality Review Study. An initial document identifying the preliminary purposes and goals for this endeavor, as well as the methodology was drafted. Committees were also composed as a means of defining specific fundamental areas of focus.

A group of the team members attended an intensive two-day training conference in Key West at the end of October, which was sponsored by the National Council of Juvenile and Family Court Judges. This conference, which was the first such training to be held on a national level, provided education on and exposure to national fatality review practices, and the many complex issues inherent in conducting reviews. Following the conference, the team members also participated in a one-day Florida Symposium on Domestic Fatalities, exclusively for the four selected Florida teams. This symposium provided an opportunity for the teams to meet, exchange experiences, and process practical application of the concepts conveyed at the conference.

In the meetings following the national conference, Miami-Dade's Review Team focused on the development of a working document outlining its mission, purposes and goals, methodology, and operating guidelines. The designated committees were more clearly defined and convened meetings on their respective issues. Planning was also undertaken for the first review, which commenced in January, 1999. A case file used in the 1994 Mortality Review was selected to begin the review process, with the idea that it would serve as an example of the types of information available for collection, and others, which may be sought after as supplements. A Case Review Plan was then developed, wherein it was determined that in order to focus on a specific population of cases from which aggregate data could be extracted and compiled for purposes of analysis and depicting trends, the review of all closed domestic violence-related deaths from 1997, onward would be undertaken. Closed cases were defined as those

cases that are domestic violence-related homicide/suicides and/or resulted in arrest with a plea being entered and are not subject to appeal.

In January of 2000, the Second National Conference on Fatality Review was convened in Orlando, specifically geared towards providing technical assistance to six new Florida teams: Broward, Fort Myers, Jacksonville, Orlando, Pensacola, and Pasco/Pinellas. The Chair of Miami-Dade's Review Team participated as faculty at this intensive training institute, as well as on a national basis on other occasions. In addition, at this conference, a statewide data collection software program was launched and provided to each of the teams. Miami-Dade County's Review Team was recognized for the creation of its data collection instrument¹, which served as the basis for the development of this software program in form and content, and was adopted on a statewide basis. Approximately fifteen teams have been created and are operating throughout the State of Florida at the current time². Teams are also operating in close to forty states nationally³.

The 2000 legislative session culminated in the enactment of key enabling legislation to support the fatality review process.⁴ Miami-Dade County was extremely supportive of this process, strongly urging the Florida Legislature to adopt the legislation via a resolution passed by the Board of County Commissioners, sponsored by Commissioner Katy Sorenson and Dr. Barbara M. Carey-Shuler, who signed on as a co-sponsor. As of 2009, twenty states across the country had enacted fatality legislation.⁵

In September of 2000, Former Miami-Dade County Mayor, Alex Penelas, recommended funding to hire a staff researcher and coordinator to support the fatality review process in his Budget Message for Fiscal Year 2000-2001, which was unanimously approved by the County Commission. Commissioner Katy Sorenson was particularly instrumental in her support of the funding allocation. National experts have noted that having a local government entity responding to the largely preventable crime of domestic homicide by recognizing the importance of allocating funding towards homicide review efforts is unprecedented in nature.

Funding has had a tremendous impact on maximizing the effectiveness of the fatality review process and data collection methods. The work of dedicated staff has enabled the Review Team to conduct reviews in a more efficient manner, doubling the number of reviews monthly. In addition, funding allowed for the enhancement of the process of capturing accurate domestic violence-related death data, which previously relied upon cases being identified through news clippings and press releases. One of the initial findings of the Review Team was that there was not an existing entity in our community to uniformly and accurately identify and capture domestic violence-related death information. Staff approached this issue by broadening their focus from self-reporting methods used by law enforcement agencies to examining *all* homicides and suicides occurring within Miami-Dade County for a given year, and uniformly determining if each individual case fell within an expanded, officially adopted definition of a "domestic violence-related death". Utilizing this refined data collection method has positioned Miami-Dade County's Domestic Violence Fatality Review Team as the repository in our community for the uniform and accurate identification and collection of domestic violence-related death information. Funding also previously allowed for the establishment of a contractual relationship with the Department of Children and Families to devise a system of geomapping and geocoding, by Commission District, as a method of depicting the data gathered, which served to further discern resources needed throughout the community.

¹ See Appendix A - DCI

² National Domestic Violence Fatality Review Initiative, Office on Violence Against Women, US Dept. of Justice.

³ NDVFRI, <http://www.ndvfri.org>

⁴ F.S. §741.316, F.S. §741.3165

⁵ NDVFRI

Both the Miami-Dade County Alliance for Human Services and the Domestic Violence Oversight Board have relied on this data in this regard to better discern social service needs.

Another significant advancement is the inclusion of local child death review. Miami-Dade County, once again, has been the first in the state to take the initiative to convert the local child death review process from one that was internal to the Department of Children and Families to one that is multidisciplinary, as per the recommendation of Florida and national child death review legislation, by merging both the adult and child death review processes under the same umbrella.⁶ This undertaking has served as a means of recognizing that family violence, including child maltreatment, must be viewed holistically. In 2002, Miami-Dade's Review Team was officially State Certified as the local entity to conduct child death reviews within Miami-Dade and Monroe County. The committees conducting both the adult and child death reviews hold their meetings at the Miami-Dade County Medical Examiner's Department on a monthly basis.

The cutting-edge work of Miami-Dade County's Domestic Violence Fatality Review Team, was recognized in April, 2002, in Tallahassee, with the receipt of the 2002 Governor's Peace at Home Award, in the category of *research*, along with an award of special recognition, which was presented to the Team's Chair for her dedication and leadership.

⁶ F.S. §383.402; F.S. §383.412

MIAMI-DADE COUNTY DOMESTIC VIOLENCE

FATALITY REVIEW TEAM

SECTION 3

MIAMI-DADE COUNTY DOMESTIC VIOLENCE

FATALITY REVIEW TEAM

**METHODOLOGY USED FOR DATA COLLECTION
TO TRACK DOMESTIC VIOLENCE-RELATED DEATHS
IN MIAMI-DADE COUNTY**

Beginning in 1998, the Review Team relied on cases being identified through news clippings and press releases. One of the initial findings was that there was not an existing entity in our community to uniformly and accurately identify and capture domestic violence-related death information. Most law enforcement agencies have a practice of excluding from the total count domestic violence-related suicides, cases involving intimate partners who fall outside of the statutory definition of domestic violence because they never resided together (dating relationships), and same sex relationships [See F.S. 741.28]. County funding allocated for the Review Team has had a tremendous impact on maximizing the effectiveness of the fatality review process and data collection methods. The efforts of the dedicated staff (a program coordinator, data analyst, and program specialist) has proven to enhance the process of capturing accurate data regarding domestic violence-related deaths.

Staff broadened their focus from self-reporting methods used by law enforcement agencies and the media, to examining *all* homicides and suicides occurring in Miami-Dade County for a given year, and uniformly determining if each individual case fell within this newly established, expanded definition of a domestic violence-related death.

For the purposes of this report, a death has been defined as being “**domestic violence-related**” when the relationship between the victim and the perpetrator is that of spouses, former spouses, family members (including persons related by present or former marriage), persons presently or formerly in a romantic or intimate relationship (regardless of whether they have resided together in the present or past), or involving any significant others of persons presently or formerly in a romantic or intimate relationship.

Table 2.1 shows the breakdown of the actual number of homicides and suicides for their respective year, information which was gathered through medical examiner and police reports. Table 2.2 demonstrates the total number of domestic violence-related deaths per year, along with the comparison of the *previous* and *new* collection methodology.

Table 2.1: Total Number of Homicides and Suicides Per Year

	1999		2000		2001		2002	
	Homicides	Suicides	Homicides	Suicides	Homicides	Suicides	Homicides	Suicides
Total	229	266	215	243	223	233	227	243
	2003		2004		2005			
	Homicides	Suicides	Homicides	Suicides	Homicides	Suicides		
Total	224	223	232	211	183	207		

Table 2.2: Comparison of Data Using Previous and New Collection Methodology

	1999	2000	2001	2002	2003	2004	2005
Total Homicide and Suicide Deaths	495	458	456	470	447	443	390
Total DV-Related Deaths Using Previous Collection Methodology	57	36	N/A	N/A	N/A	N/A	N/A
Total DV-Related Deaths Using New Collection Methodology	79	72	72	75	62	65	39

Since its inception in May 1998, the Review Team has been comprised of community leaders as well as interagency representatives in order to accomplish system improvements through community-wide collaboration. Consequently, communication between the various agencies has improved, creating a process of accountability.

The future encompasses maintaining working relationships with all police municipalities that have their own dedicated domestic violence unit and with the seven municipalities that have homicide investigative bureaus (Miami-Dade, City of Miami, Aventura, Miami Beach, North Miami Beach, Hialeah, and North Miami) to uniformly identify domestic violence death cases. Through the Miami-Dade Chiefs of Police, protocols have been established with each municipality for the report of future incidents. In conjunction with collaborating with law enforcement, the Review Team partnered with the Department of Children and Families in order to devise a system of geomapping and geocoding of data gathered from 1999 – 2003.⁷

⁷ Refer to Appendix B for geomapping of Miami-Dade homicide data and domestic violence-related homicide and suicide data by district.

FATALITY REVIEW TEAM**RESULTS OF COUNTYWIDE DOMESTIC VIOLENCE-RELATED
FATALITY DATA**

Through our collection methodology, the following data is derived from the cases that were deemed domestic violence-related deaths for the years 1999 through 2005. In total, there were 464 domestic violence-related fatalities during these years. Table 1 divides these deaths by type of incident for their respective years. Of these 464 deaths, 124 deaths were a result of suicide incidents, 200 deaths were a result of homicide incidents, 62 deaths were *suicides* from homicide/suicide incidents, and 72 deaths were *homicides* from homicide/suicide incidents. Six additional domestic violence-related deaths did not fall into these categories. For these incidents, the manner of death was homicide as a result of a police-involved shooting. Several variables were analyzed with respect to these fatalities and incidents. Among them were gender, race, age, and cause of death.

Table 2.3: Yearly Number of Deaths by Type of Incident

	1999	2000	2001	2002	2003	2004	2005	TOTAL
Suicides	28	19	21	16	18	11	11	124
Homicides	31	31	30	30	23	38	17	200
Homicide/Suicides	20	22	20	28	20	14	10	134
Other	0	0	1	1	1	2	1	6
TOTAL	79	72	72	75	62	65	39	464

The 464 domestic violence-related *deaths* were a result of 377 domestic violence-related *incidents*.⁸

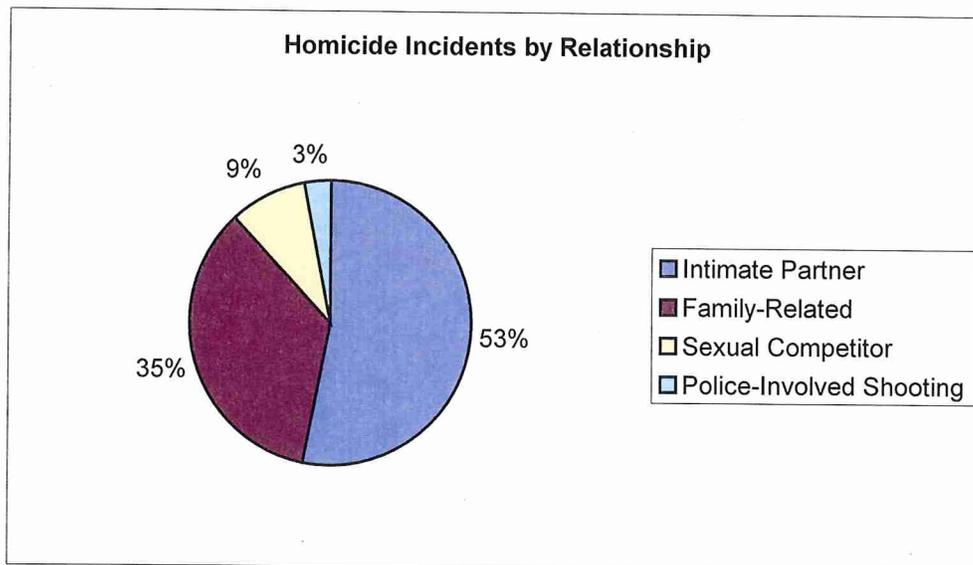
The breakdown of countywide domestic violence-related fatalities for homicide, homicide/suicide, and suicides is as follows:

⁸ When looking at domestic violence-related fatalities, incidents and deaths must be looked at separately. *Incident* refers to the action, while *deaths* refer to the number of deceased.

I. HOMICIDES

The majority of domestic violence-related fatalities fall under the category of homicide. Within the category of domestic violence-related homicides there are both adult and child victims. In addition to the variables of race, gender, age, and cause of death, the type of relationship between the perpetrator and the decedent was also examined.

Consistent with national research findings, the majority of the domestic-related deaths were intimate partners (53%). Thirty-five percent (35%) were family-related, 9% were deaths involving a sexual competitor, and 3% were a result of a police-involved shooting. There were no homicide deaths due to mercy killing, resulting from homicide incidents, in Miami-Dade County for these years.



A. Intimate Partner Homicide

Intimate partner homicide was further divided into three types: those that were *current or formerly married partners*, *heterosexual unmarried partners*, and *same-sex partners*. The following table illustrates the number of deaths for each:

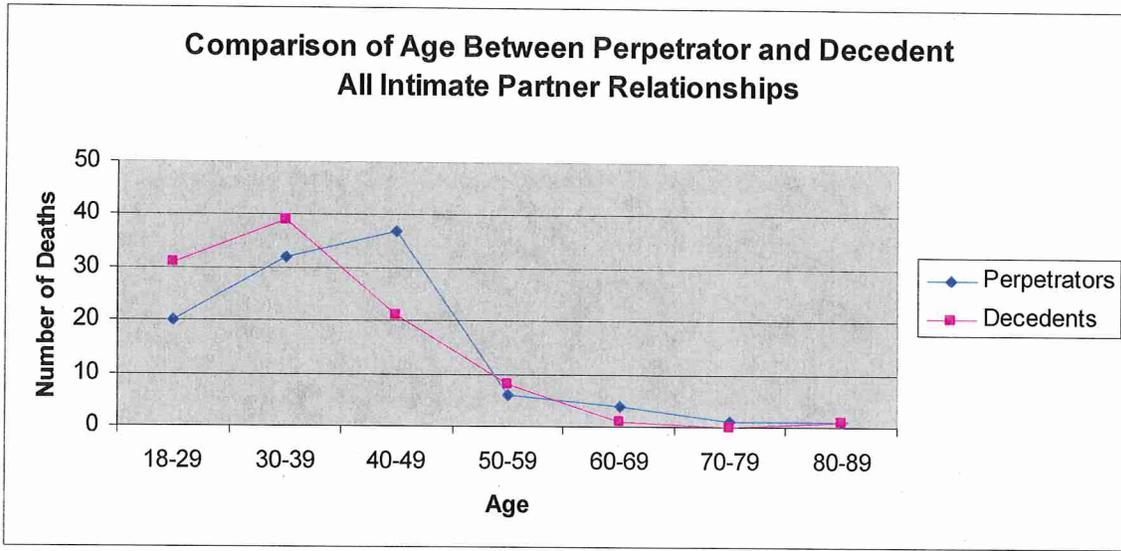
Table 2.4: Number of Deaths per Type of Intimate Partner Relationship

Current or Former Married Partners	Heterosexual Unmarried Partners	Same-Sex Partners	TOTAL
43	51	7	101

The following results were found:

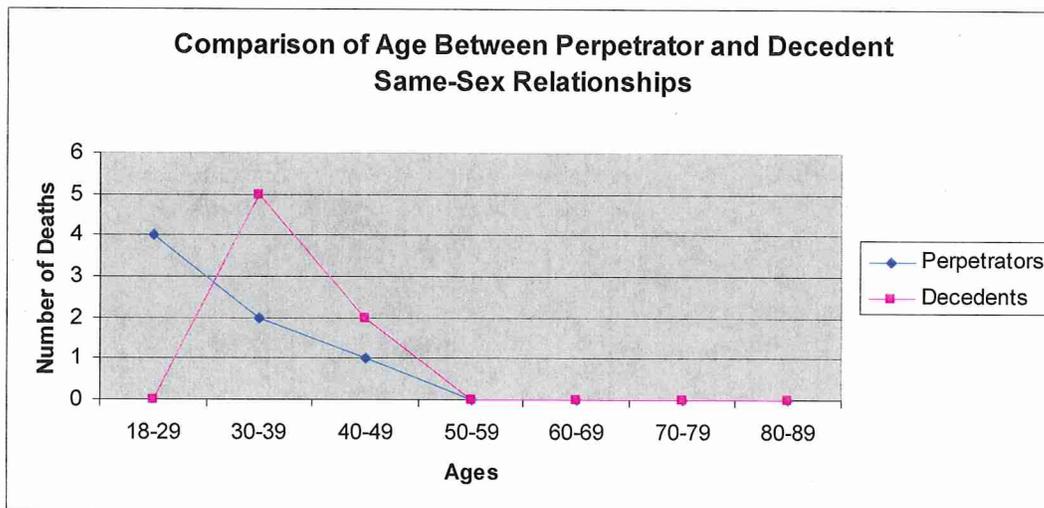
Age

The victims and perpetrators of these intimate partner homicides were generally under 50 years of age. Of the decedents, 90% were under 50, and of the perpetrators, 88% were under 50. As seen in the following figure, in the majority of deaths, perpetrators of intimate partner homicide tended to be older than their victims. That is, more perpetrators than decedents fell in the age ranges above 40.



* Includes heterosexual and same-sex relationships

However, when analyzing the data for same-sex relationships, it appears that the opposite is true. Out of the seven same-sex intimate partner homicides, five of the victims were between the ages of 30-39, and two were between the ages of 40-49. When looking at the ages of the perpetrators of same-sex domestic homicide, four were classified between the ages of 18-29⁹, two were between the ages of 30-39, and one was between the ages of 40-49.



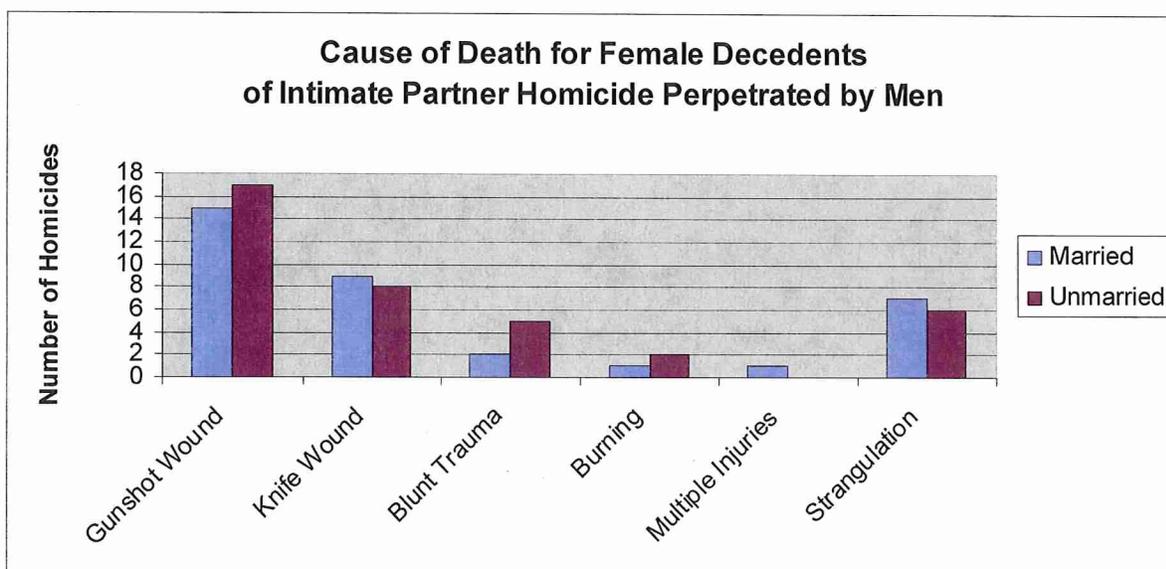
⁹ One perpetrator was 17 years-old at the time of the fatal incident.

Gender

The majority of the decedents of intimate partner domestic homicide were females (72%). However, when same-sex relationships were analyzed separately, this was not the case. Same-sex relationships involving domestic homicide were exclusive to male partners. Additionally, when intimate partner domestic homicides that did not involve a same-sex relationship were examined separately, the percentage of female decedents rose to 78%.

Cause of Death

For intimate partner homicide, excluding same-sex relationships, there were 73 male perpetrators. The following chart displays the cause of death of intimate partner homicide with respect to these perpetrators.



There were 21 female perpetrators of intimate partner domestic homicide. The majority, or 13 of these perpetrators, were not married to the decedent. Further, the main cause of death of these decedents was by knife wound (62%), with no noteworthy difference between married and non-married partners. The remaining percentage was killed as a result of a gunshot wound.

For the seven same-sex intimate partner homicides, the cause of death varied. Two were killed as a result of stabbing, two as a result of multiple injuries, one as a result of strangulation, one as a result of blunt head trauma, and one from a gunshot wound.

Additional Findings

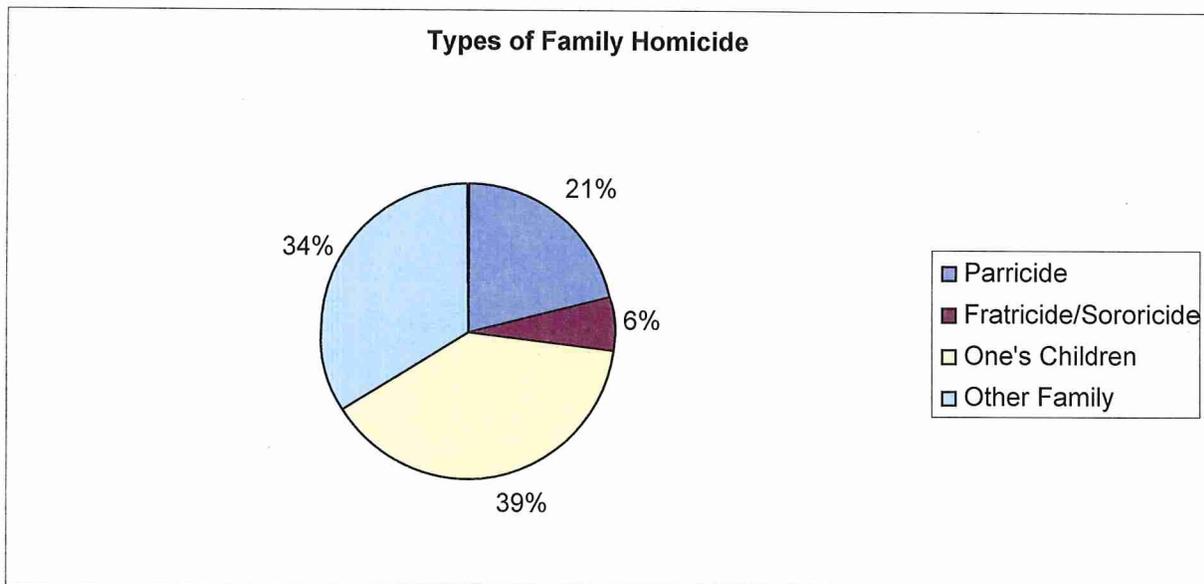
Gender, age, and type of relationship were examined simultaneously. With married and non-married domestic homicide, the data suggests that the age group with the highest risk is for those individuals between the ages of 30-39. This trend is consistent regardless of decedent gender. Men are 24% more likely to be victims of domestic homicide if they are unmarried to the perpetrator. Women, however, are in general, more likely to be victims of domestic homicide. For women, the type of relationship did not appear to determine risk. Rather, the data implies that for female decedents, unmarried women appear to be younger than married women.

B. Sexual Competitor Homicide

An additional category of sexual competitor was analyzed. This category examined the death of the former or present lover of the perpetrator's current or former intimate partner. For example, when a perpetrator killed the ex-boyfriend of his current girlfriend, this would be considered a sexual competitor homicide. These types of deaths were exclusive to male perpetrators. In addition, the majority of these deaths were caused by a firearm (71%).

C. Family-Related Homicide

Several forms of family-related homicide were examined: parricide (the killing of one's parents), fratricide or sororicide (sibling killings), the domestic killing of one's children, and an additional category of other family members was added to include in-laws, aunts/uncles, and acquaintances.



Characteristics of Perpetrators

With respect to gender, female perpetrators were found only in the domestic killing of one's children, with the exception of one incident in the "other family" category. The other categories of family homicide were exclusive to male perpetrators.

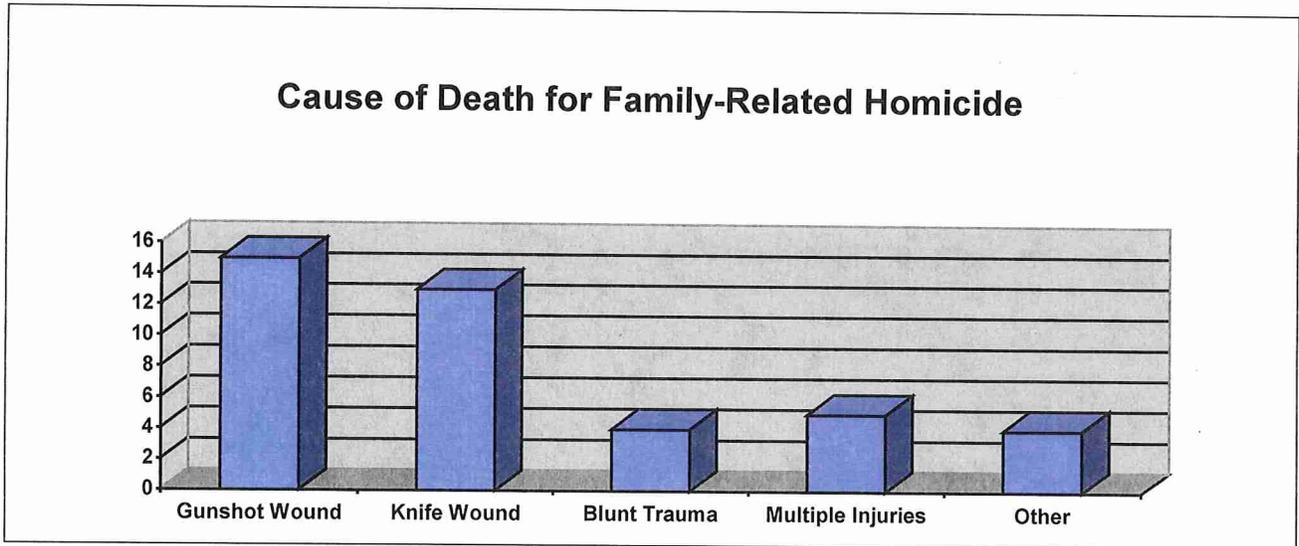
Relationship to Victim

The data revealed 26 homicide incidents involving the perpetrators' own children.¹⁰ Blunt trauma was the cause of death for 69% of these incidents.

¹⁰ "Own children" is defined as either biological or non-biological for purposes of this analysis.

Cause of Death

Gunshot wounds appear to be the cause of death for the majority of intimate partner homicide, this also holds true when looking at family-related homicide, excluding the killing of one's children. In comparing this cause of death from the cause of death of intimate partner-related homicides, one can reasonably infer that intimate partner-related homicides are the most premeditated of homicides within these two groups. The following illustrates the data revealing cause of death concerning these categories.



II. HOMICIDE/SUICIDES

An article, published by the Miami Herald, reported on a national study by Dr. Donna Cohen examining homicide-suicides across the country between 1997 through 1999. This study found that “Florida had the most reported homicide-suicides” for those years.¹¹

There were a total of 62 homicide/suicide *incidents* in Miami-Dade County in the years 1999 through 2005. The total number of *deaths* resulting from these incidents was 134.

Table 2.5: Number of Homicide/Suicide Incidents and Deaths

Homicide/Suicide Incidents	Homicide/Suicide Deaths
62	134

Of the 134 deaths, 62 were *perpetrators* of the homicide/suicide incidents, and 72 were *decedents*.

Table 2.6: Number of Homicide/Suicide Perpetrator and Decedent Deaths

Homicide/Suicide Perpetrator Deaths	Homicide/Suicide Decedent Deaths
62	72

Of these 62 incidents, three incidents involved female perpetrators, one of which resulted in the death of the perpetrator’s two minor children. Another two incidents involved male same-sex intimate partner violence. Fifty (50) incidents involved male perpetrators of heterosexual intimate partner relationships, with no noteworthy differences between married and non-married partners. Notably, one incident was categorized as a mercy killing, rather than due to intimate partner violence. Three cases involved the killing of minor children (4 deaths in total) as a result of an intimate partner domestic violence-related homicide/suicide incident. Additionally, for male perpetrated homicide/suicide incidents, one incident was categorized as a sexual competitor violence incident, and six incidents were family violence-related, of which one incident involved the killing of one’s minor child.

Age

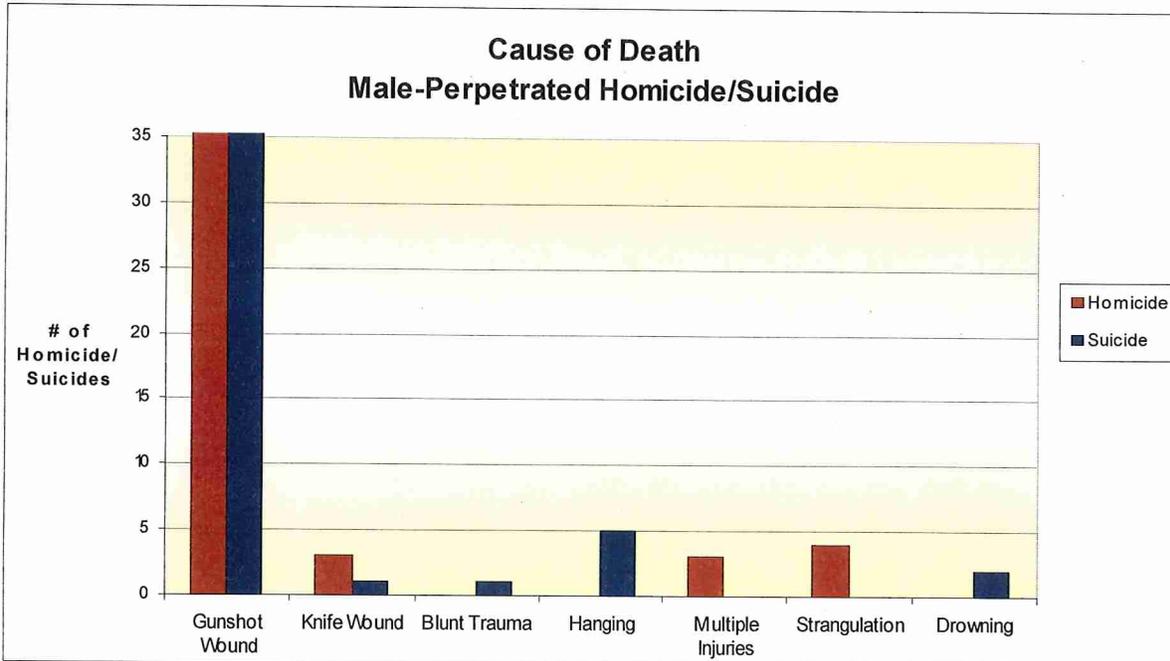
For same-sex relationships, the age pattern seen in the homicide data was not consistent with these types of incidents. For the two same-sex homicide/suicides, the perpetrator was older than the decedent. For one incident, the perpetrator was over two times the age of the decedent. For the other incident, the age difference was less pronounced. Furthermore, unlike the homicide incidents, the ages of the married and non-married decedents, excluding same-sex partners, was considerably different. Consequently, age differences between the parties involved, particularly, in intimate partner homicide/suicide, may be viewed as a risk indicator. This finding is consistent with a national study on murder-suicide reporting that, “studies on fatal violence for spouses have found that there is a greater risk of homicide victimization as the age difference between the husband and wife increases.”¹²

¹¹ “Murder-Suicide ‘epidemic’ in Florida” *The Miami Herald* July 29, 2001.

¹² “American Roulette, The Untold Story of Murder-Suicide in the United States.” *Violence Policy Center*, 2002.

Cause of Death

For homicide/suicides involving a same-sex perpetrator, the cause of death for the decedents were both knife wounds, while the cause of death for the perpetrator was equally divided between a gunshot wound and knife wound. For the three incidents involving a female perpetrator, in two incidents the cause of death for both the decedents and the perpetrators was a gunshot wound, the other incident involved the drowning of the perpetrator and her two minor children. Male perpetrators of homicide/suicide were more likely to use a firearm than any other form of weapon.¹³ The following diagram displays the cause of death for both the decedents and perpetrators:



¹³ This does not include same-sex male perpetrators.

III. MULTIPLE KILLINGS

For the purpose of this report, multiple killings is defined as an incident that has more than one decedent. There were a total of 18 incidents involving multiple killings, two of which were perpetrated by females. These resulted in 50 deaths, 41 of which were victims of homicide, eight of which were perpetrators that also committed suicide, and one was a perpetrator that was involved in a police shooting.

Table 2.7: Breakdown of Multiple Killings by Incidents

Homicide Incidents	Homicide/Suicide Incidents	Total Incidents
10	8	18

Table 2.8: Breakdown of Multiple Killings by Deaths

Homicide Deaths	Suicide Deaths	Total Deaths
41	8	50

Fifty percent (50%) of these incidents involved an intimate partner decedent, which were all female victims. A total of 14 minor children (under the age of 18) were killed as a result of these incidents.

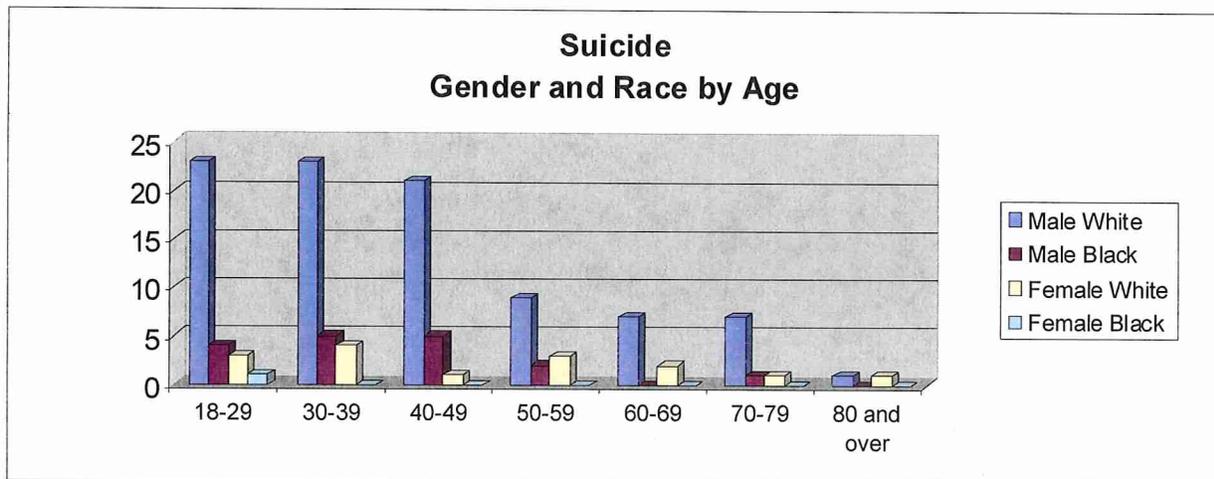
IV. SUICIDES

When analyzing domestic-related deaths, suicides have traditionally been ignored as a category. However, the national trend is to recognize these deaths when compiling domestic violence-related fatality data. The suicide acts range from incidents involving a suicide after a domestic altercation has taken place, to the completion of a suicide after an attempted murder of an intimate partner or relative, to the commission of a suicide in the house of a former intimate partner after the termination of the relationship. Each of the suicide cases included in the Review Team's data have been carefully reviewed and analyzed to ensure a close nexus exists between the suicide act and the presence of domestic violence between the parties. In addition, literature suggests that the effect of the suicide has an immediate and long-lasting traumatic effect on the family, both intimate partners and especially children, which needs to be addressed. One important factor in preventing fatalities is to bring these incidents to the attention of the public and community agencies.

Among the 102 total suicides between 1999 and 2005, the following was observed:

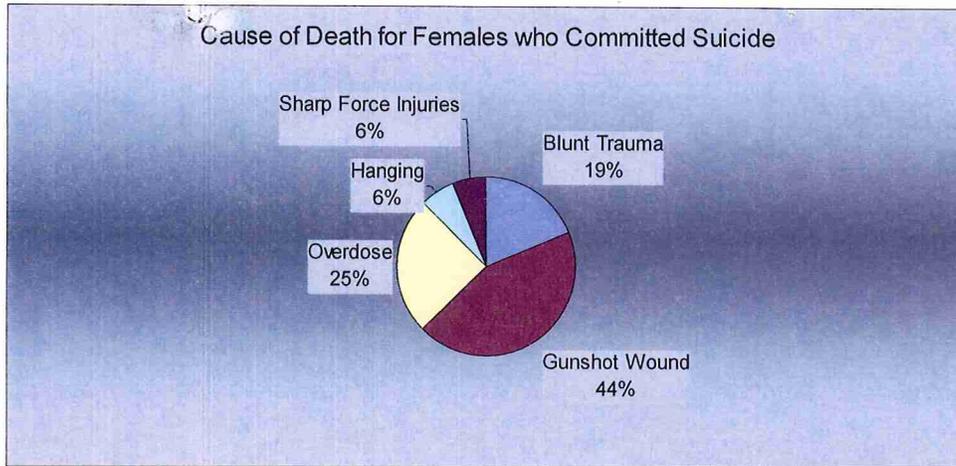
Age, Race, and Gender

Seventy-three percent (73%) of the decedents were under the age of 50, 87% were male, and 85% were white. There were some differences in gender with respect to age. Younger males were more likely to commit suicide, but for females the differences in the age groups were less pronounced.

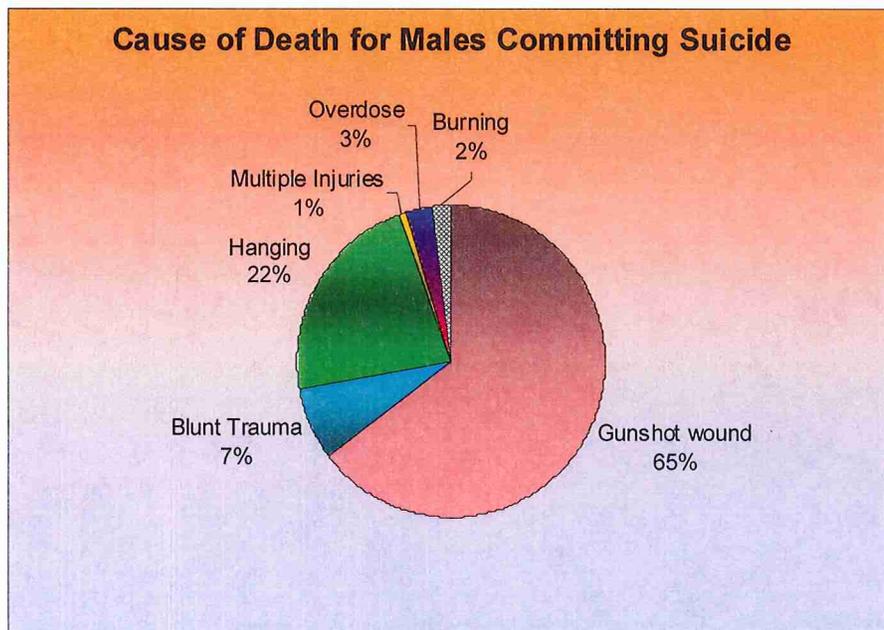


Cause of Death

The majority of these incidents were committed using a firearm. Out of the 16 women that committed suicide, seven of the deaths were caused by a gunshot wound, four were due to overdose of medication, three to blunt trauma, one was due to hanging, and one was due to knife wounds. In two of these incidents, there was a documented homicide attempt on the perpetrator's intimate partner directly preceding the suicide incident.



The following chart demonstrates the cause of death for male perpetrated suicide. Notably, for 10 of these incidents, there was a documented homicide attempt on the perpetrator's intimate partner directly preceding the suicide incident.



V. DOMESTIC VIOLENCE-RELATED CRIME TRENDS

The Florida Department of Law Enforcement (FDLE) has released data and statistics regarding domestic violence crime rates in each county. The following table shows this information, along with the total number of domestic violence deaths in the state reported by FDLE.¹⁴

Table 2.7: FDLE Reported Domestic Violence (DV) Deaths

Year	DV Deaths in Miami-Dade	DV Deaths in Florida	% of DV Deaths in Miami
1992	71	255	28%
1993	61	250	24%
1994	64	240	27%
1995	54	209	26%
1996	30	209	14%
1997	22	170	13%
1998	23	212	11%
1999	27	199	14%
2000	34	178	19%
2001	34	211	16%
2002	34	194	18%
2003	22	179	12%
2004	26	184	14%
2005	16	176	9%

As can be seen, the trend shows a substantial decrease in domestic violence-related deaths in Miami-Dade County since 1992. One change in the system at this time was the inception of Miami-Dade's Domestic Violence Court in 1992. The number of referrals to mandated batterers intervention programs in misdemeanor domestic violence and civil injunction cases, holding the batterer accountable, and providing services to the victim and children may be a factor in lowering the number of domestic violence-related deaths in the county.

With the inception of our new data collection methodology, the number of domestic violence-related deaths recorded in Miami-Dade County was greater than in the previous years. Rather than being the result of a trend, the apparent increase in numbers is generally due to the expanded definition of domestic violence-related deaths and our procedure to collect this information through the Medical Examiner's Office rather than the individual police departments. In addition, FDLE does not include domestic violence-related suicides in their data.

¹⁴ FDLE defines domestic violence-related deaths as the total number of domestic violence-related homicides and manslaughter charges. FDLE does not include suicides in domestic violence-related death data.

The following statistics and figures refer to the comparisons between our data and FDLE's data:

**Table 2.8:
FDLE Reported Domestic Violence (DV) Deaths vs. DVFRT Domestic Violence (DV) Deaths**

Year	FDLE Reported DV Deaths in Miami-Dade	DVFRT Reported DV Deaths in Miami-Dade	% Difference
1992	71	--	--
1993	61	--	--
1994	64	--	--
1995	54	--	--
1996	30	--	--
1997	22	--	--
1998	23	--	--
1999	27	79	192%
2000	34	72	112%
2001	34	72	112%
2002	34	75	121%
2003	22	62	182%
2004	26	65	150%
2005	16	39	144%

In conclusion, there were 101 intimate partner-related homicides and 60 intimate partner decedents from homicide/suicides. This figure alone demonstrates that at least 60% of these deaths stem from intimate partner violence. Additionally, many incidents that resulted in the death of one's children, other family members, and sexual competitors, occurred in the context of intimate partner violence, as did most of the 124 suicide incidents. Family violence also accounts for a substantial amount of domestic violence-related deaths. The following sections are dedicated to analyzing data regarding child deaths as a result of abuse and/or neglect, as well as the analysis of aggregate data, mostly concerning intimate partner violence, that was obtained from cases reviewed between 1997 and 2005.

MIAMI-DADE COUNTY DOMESTIC VIOLENCE

FATALITY REVIEW TEAM

SECTION 4

MIAMI-DADE COUNTY DOMESTIC VIOLENCE
FATALITY REVIEW TEAM

AGGREGATE DATA SUMMARY OF CASES REVIEWED

The following data represents a sample of cases *from the years 1997-2005* that were reviewed by the Review Team. Information for the reviews was acquired through police reports, newspaper clippings, and representative team member organizations. The scope of Miami-Dade County's Domestic Violence Fatality Review process is exclusive to the review of closed cases. As most of the domestic fatalities occurring in Miami-Dade County have involved intimate partner-related violence, the majority of the cases reviewed were such. In addition, due to the nature of homicide/suicide incidents being closed cases, the majority of cases reviewed were such. The data was analyzed separately for male and female perpetrators. The following sections involve the analysis of male perpetrators of single intimate partner killings, male perpetrators of multiple intimate partner-related killings, female perpetrators of intimate partner homicide, family homicide, and sexual competitor homicide.

- Between 1999-2005, the **total number of cases reviewed** was **119**.¹⁵
- The **total number of decedents** resulting from these cases was **136**.¹⁶

I. INTIMATE PARTNER HOMICIDE

The total number of intimate partner homicide cases reviewed was **112**. Of these cases, 102 involved male perpetrators and 10 involved female perpetrators. Moreover, out of the 102 cases involving male perpetrators, 11 cases had multiple decedents.

Fifty-six (56) of the cases reviewed involved male perpetrators that committed suicide. One female perpetrator committed suicide.

Cases where the **MALE PERPETRATOR** was arrested revealed the following:

- Eight cases resulted in a conviction of First Degree Murder, all of which were sentenced to Life in prison without the possibility of parole.
- In one case, the perpetrator was acquitted by the jury of First Degree Murder.
- Eighteen cases resulted in a conviction of Second-Degree Murder. The sentencing for these ranged from 12 years in state prison with subsequent probation to Life in state prison.
- Eight cases resulted in a conviction of Manslaughter. The sentencing for these ranged from four years of community control/probation to 30 years in state prison.
- Two cases resulted in convictions of reckless driving and reckless display of a firearm, respectively.
- One case was nolle prossed by the State Attorney's Office because it was not possible to prove, beyond a reasonable doubt that the perpetrator did not act in self-defense, as he had asserted.
- In one case, the perpetrator pled to Manslaughter, a withhold of adjudication was entered, and the perpetrator was sentenced to five years of community control with subsequent probation.
- One case was deemed justifiable homicide and charges were not pursued by the State Attorney's Office.
- In two cases, the perpetrator was not arrested because he was either killed in a police-involved shooting, or killed by someone else, prior to being taken into custody.

¹⁵ Includes all intimate partner, family homicide and sexual competitor homicides.

¹⁶ Does not include perpetrators who also committed suicide.

Cases where the **FEMALE PERPETRATOR** was arrested revealed the following:

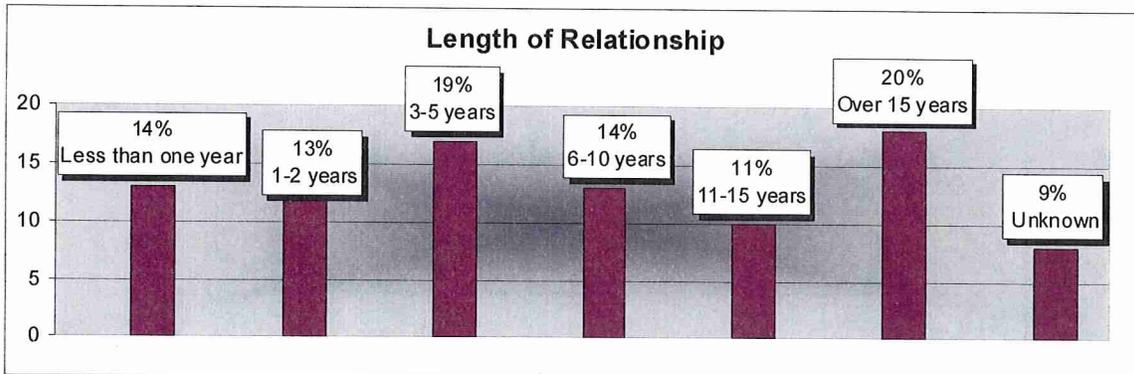
- Two cases were deemed justifiable homicides and charges were not pursued by the State Attorney's Office.
- One case resulted in a First Degree Murder charge and the female perpetrator was sentenced to Life in prison.
- Three female perpetrators were convicted of Second Degree Murder. The sentencing ranged from nine years in state prison to 35 years in state prison.
- Three cases resulted in a conviction of Manslaughter. Sentencing for these ranged from less than one year of jail time with subsequent probation to 10 years in state prison.

A. MALE PERPETRATOR

The following are findings from the review of the 91 cases involving MALE perpetrators of intimate partner *single* killings:

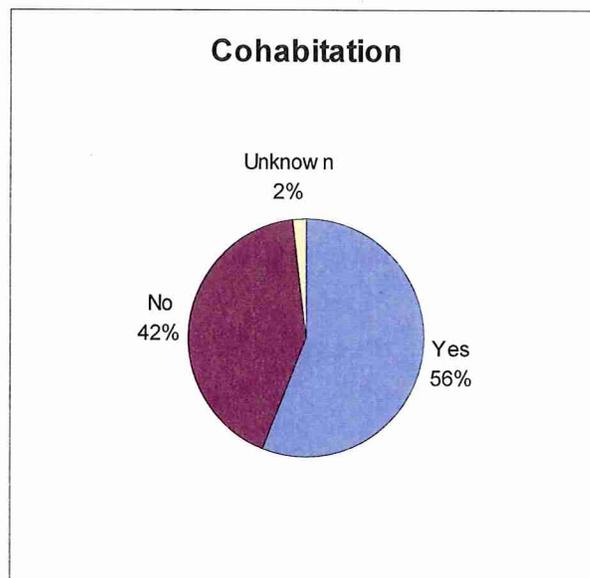
Length of Relationship

Fourteen percent (14%) of the cases involved partners that were in a relationship for less than one year. Forty-six percent (46%) involved partners involved for less than five years. Sixty percent (60%) were involved for less than 10 years.



Cohabitation

Fifty-six percent (56%) of these partners were living together at the time of the incident, 42% were not living in the same residence at the time of the fatal incident, and it is unknown where 2% of these partners were residing.

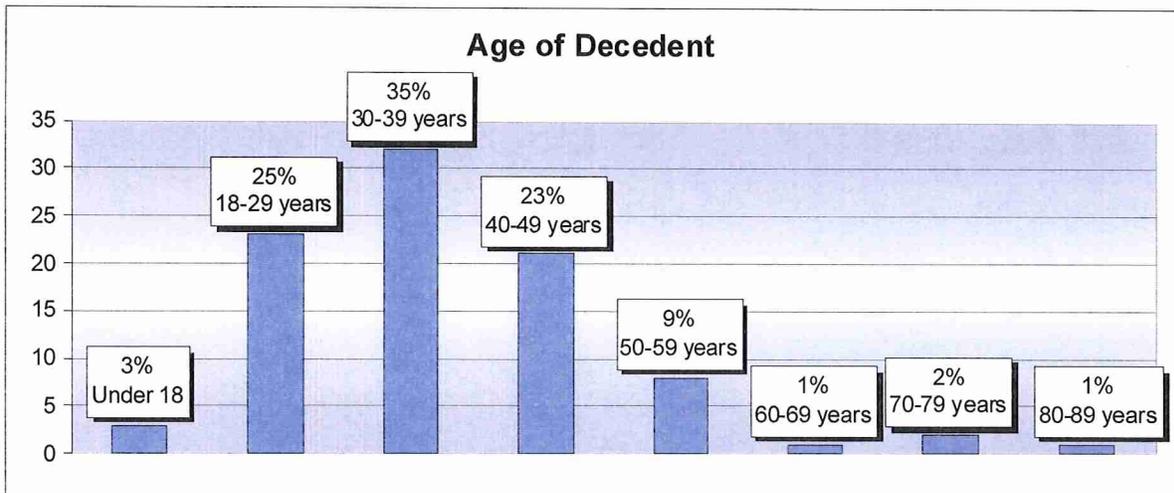


Separation Between Parties

Thirty-six percent (36%) were separated at the time of the incident. Of those that were not separated, a substantial amount evidenced some intention to leave. Of those partners that had separated, a major portion (67%) were separated for less than 6 months.

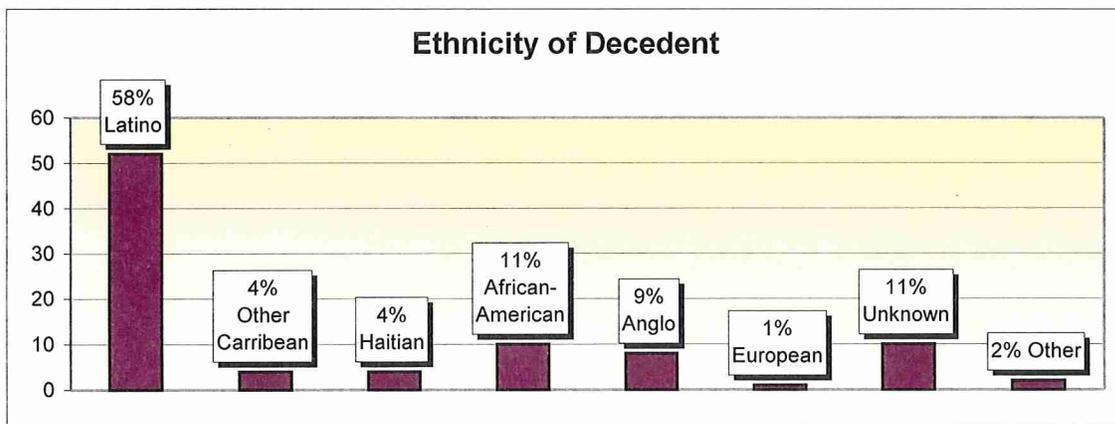
Age of Decedent

Consistent with the analysis of the countywide domestic violence fatality data, the aggregate data from the case reviews revealed that 35% of the victims in this category were between the ages of 30-39. Additionally, 86% were between the ages of 18-49.



Race and Ethnicity of Decedent

With respect to race, 70% of the decedents were white, and 29% were black. These findings are inconsistent with national findings, which suggest that black women are more likely to be victims of domestic homicide.¹⁷ However, in terms of ethnicity, 58% of the decedents were of Latino origin.



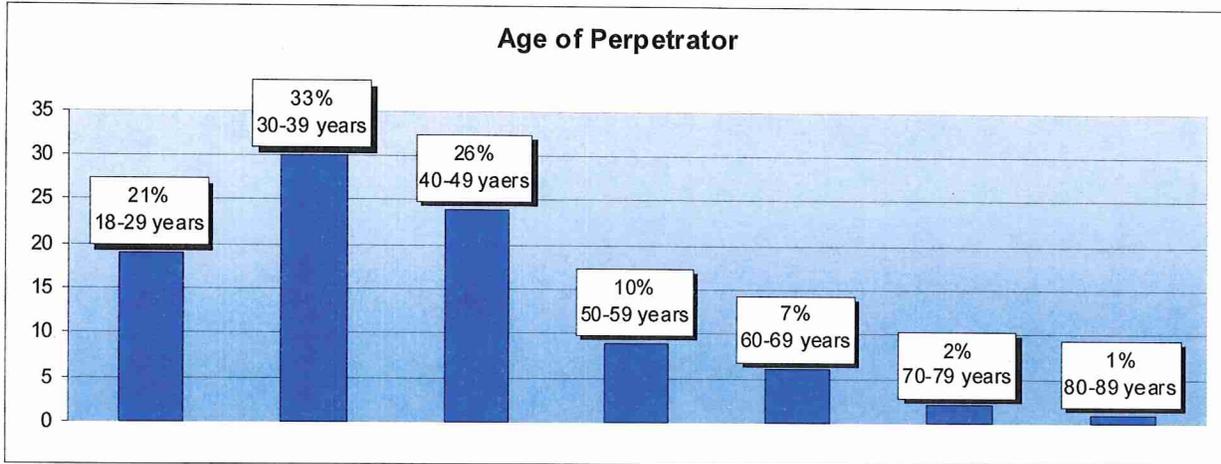
¹⁷ Websdale, Neil. 1999. *Understanding Domestic Homicide*. Boston: Northeastern University Press.

Employment Status of Decedent

Sixty-seven percent (67%) of the decedents were employed, 21% were not, and 12% of the decedents' employment status was undetermined.

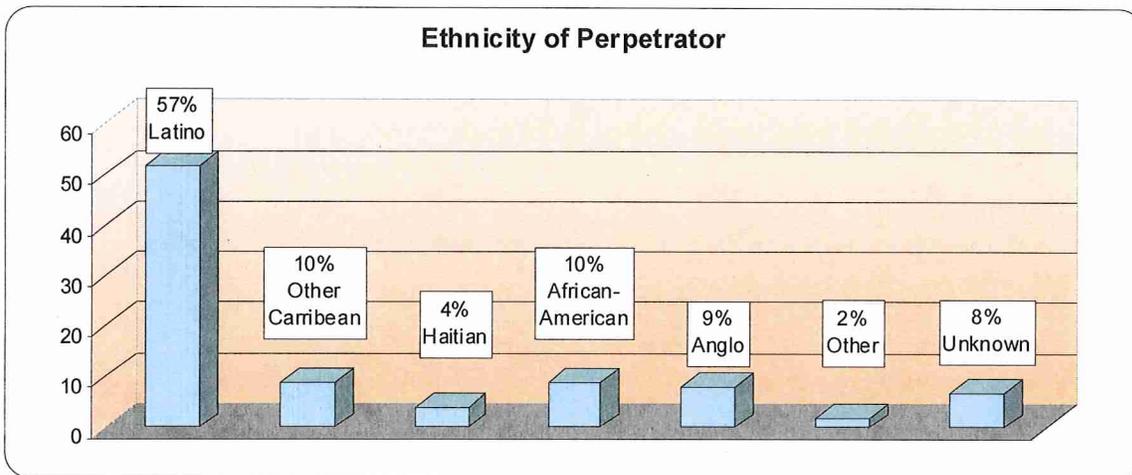
Age of Perpetrator

The majority of the perpetrators were between the ages of 30-39 (33%), and 80% were between the ages of 18-49.



Race and Ethnicity of Perpetrator

Fifty-six percent (56%) were black, 43% were white, and 1% of the races were undetermined. Additionally, 57% of the perpetrators were of Latino origin.

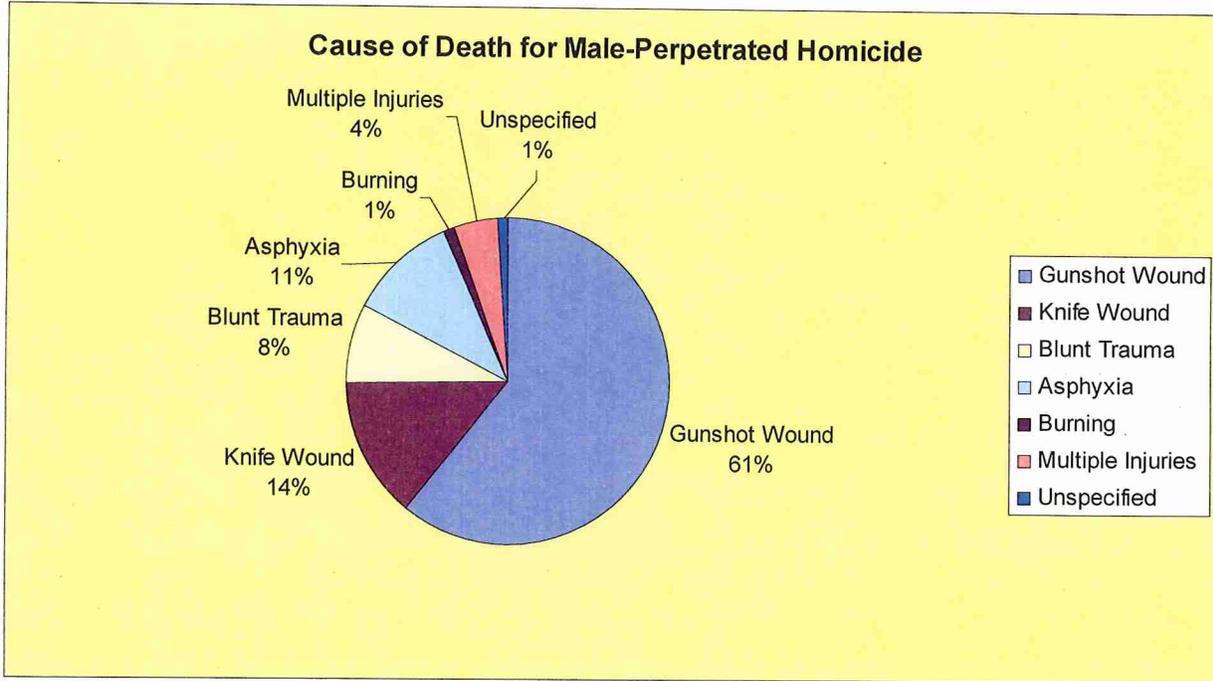


Employment Status of Perpetrator

Sixty-five percent (65%) of the perpetrators were employed, 31% were not, and 4% of the perpetrator's employment history was undetermined.

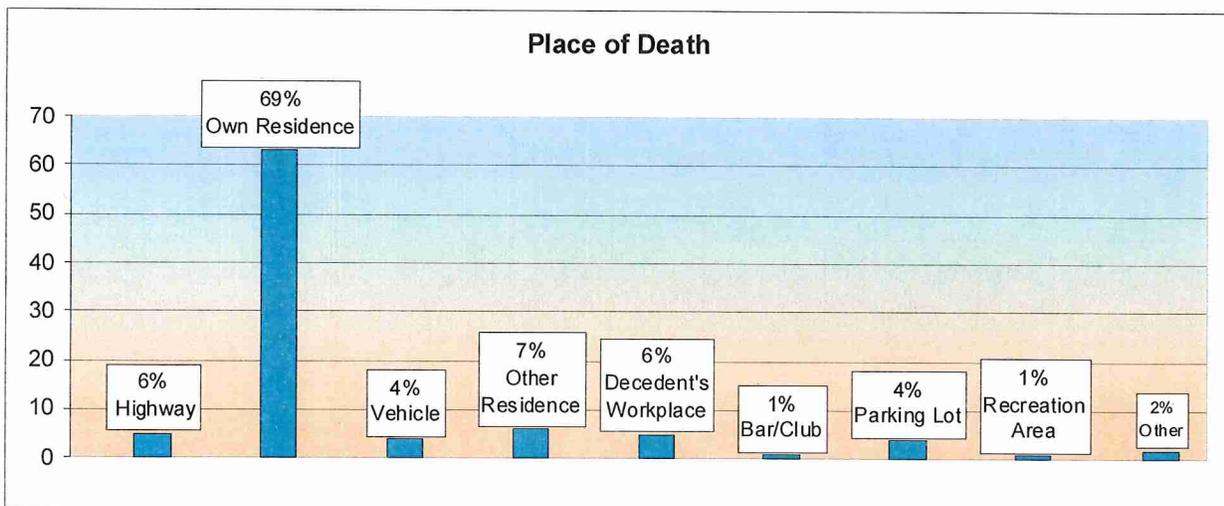
Cause of Death

Consistent with the countywide domestic violence fatality data analysis, 61% of these homicides were caused by a gunshot wound(s), 14% were caused by a knife wound(s), 11% were caused by asphyxia, another eight percent (8%) were caused by blunt trauma, four percent (4%) were caused by multiple injuries, one percent (1%) was caused by thermal injury (burning), and one percent (1%) of the causes was unspecified.



Place of Death

Sixty-nine percent (69%) of these murders were committed at the decedent's own residence.



Toxicology Findings of Perpetrators who Committed Suicide

Between 1995 and 2003, fifty-four (54%) of the perpetrators who committed suicide were under the influence of alcohol and/or drugs at the time of the fatal incident. Twenty-three percent (23%) were under the influence of alcohol, 20% were under the influence of drugs, and 11% were under the influence of both. For following two years, 51% of the perpetrators that committed suicide were under the influence of alcohol and/or drugs at the time of the fatal incident. Nineteen percent (19%) were under the influence of alcohol, 13% were under the influence of drugs, and 19% were under the influence of both.

Witnessing of Fatal Incident by Children

In 19% of the incidents, children witnessed the homicide, either visually or within earshot.

Domestic Violence History Between Perpetrator and Decedent

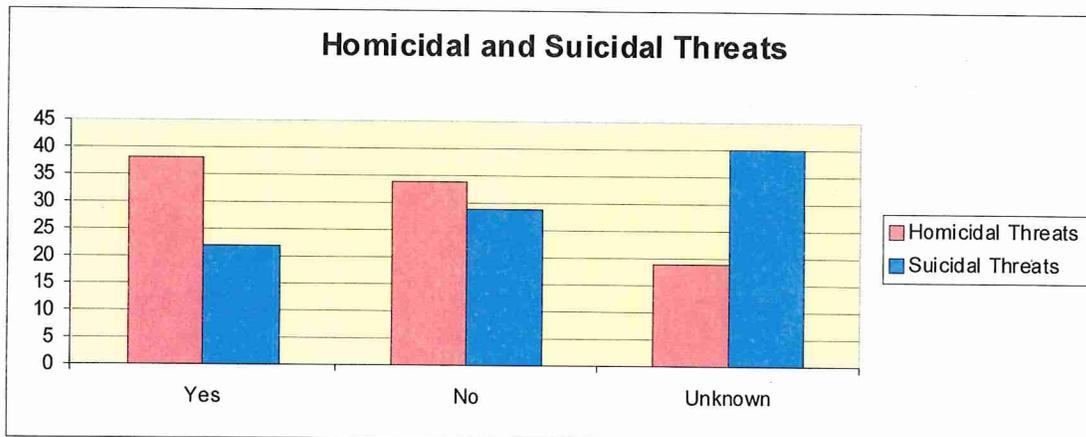
Thirty-eight percent (38%) of these cases revealed at least one prior domestic violence police report. Fifty-six percent (56%) revealed prior domestic violence reports to friends and/or family members.

History of Stalking by Perpetrator

Thirty-four percent (34%) revealed a history of stalking by the perpetrator. Notably, in 26% of the cases reviewed this information was unknown.

Presence of Death Threats and/or Suicidal Threats

In 42% of the cases there were known homicidal threats by the perpetrator against the decedent prior to the event. In 24% of the cases, the perpetrator made at least one known suicidal threat prior to the fatal incident.



Injunction Actions

Fifteen decedents (16%) had sought an Injunction for Protection against Domestic Violence against the perpetrator in the past.

Shelter Services

Four decedents (4%) had shelter involvement with a local domestic violence center.

Criminal History of Perpetrator

Of the 91 cases reviewed,

- Twenty-four perpetrators (26%) had a domestic violence criminal history, either misdemeanor or felony.
- Forty-three perpetrators (47%) had a criminal record that did not involve domestic violence-related offenses.
- Of those perpetrators that had a domestic violence criminal record, eight (33%) were referred to a batterers' intervention program, of which five (63%) had completed the program prior to the fatal incident.

DCF Involvement

Twenty-five percent (25%) of these cases had some involvement with the Protective Services Division of the Department of Children and Families.

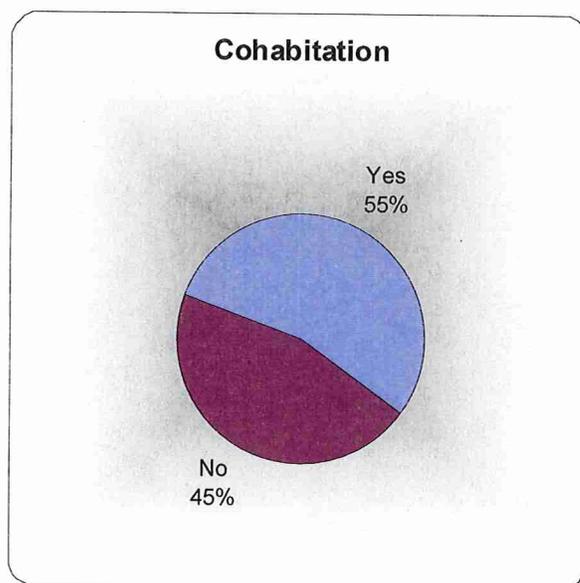
The following are findings from the review of the 11 cases involving MALE perpetrators of intimate partner *multiple* killings:

Length of Relationship

Eighty-two percent (82%) of the cases involved partners that were in a relationship for over two years. The length of relationship for one case was undetermined.

Cohabitation

Forty-five percent (45%) of these partners were *not* living together at the time of the incident, and 55% were living together at the time of the fatal incident.



Separation Between Parties

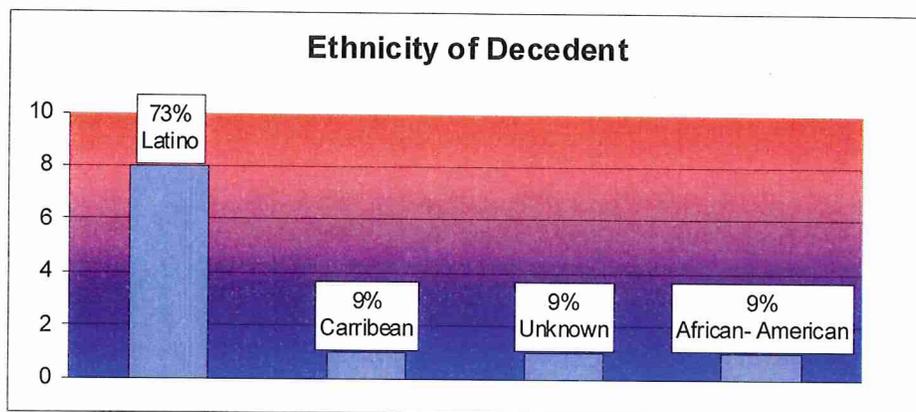
Thirty-six percent (36%) were separated at the time of the incident. Of those partners that had separated, 100% were separated for less than 6 months. For three out of the seven remaining cases, the decedent had expressed intent to leave.

Age of Decedent

Consistent with the analysis of the countywide domestic violence fatality data, the aggregate data revealed that 64% of the victims in this category were between the ages of 30-39.

Race and Ethnicity of Decedent

With respect to race, 82% of the decedents were white, and in terms of ethnicity, 73% were of Latino background.



Employment Status of Decedent

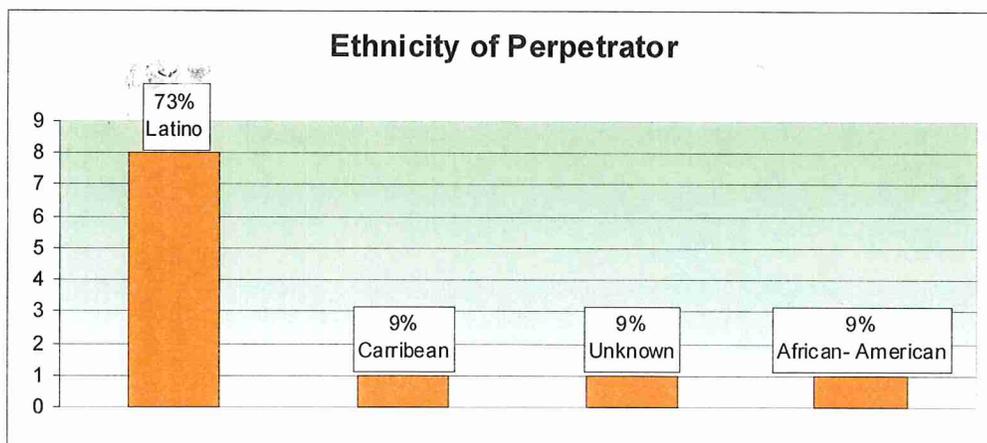
Fifty-five percent (55%) of the decedents were employed, 27% were unemployed, and 18% of the decedents' employment status was undetermined.

Age of Perpetrator

The data indicates that perpetrators of multiple killings are generally older than those that commit single killings. Seventy-three percent (73%) of these were over the age of 40.

Race and Ethnicity of Perpetrator

In addition, 64% of the perpetrators were white and 36% were black. Seventy-three percent (73%) were of Latino background.



Employment Status of Perpetrator

Sixty-four percent (64%) of the perpetrators were employed, another 27% were unemployed, and 9% of the perpetrators' employment history was undetermined.

Cause of Death

Ten of the 11 incidents involving intimate partner multiple killings were caused by a gunshot wound(s). One incident was caused by a knife wound.

Place of Death

Sixty-four percent (64%) of these murders were committed at the decedent's own residence, 18% at another residence, 9% in a highway or street, and 9% in a parking lot.

Toxicology Findings of Perpetrators who Committed Suicide

Of the eight perpetrators that committed suicide, one was under the influence of drugs at the time of the fatal incident.

Witnessing of Fatal Incident by Children

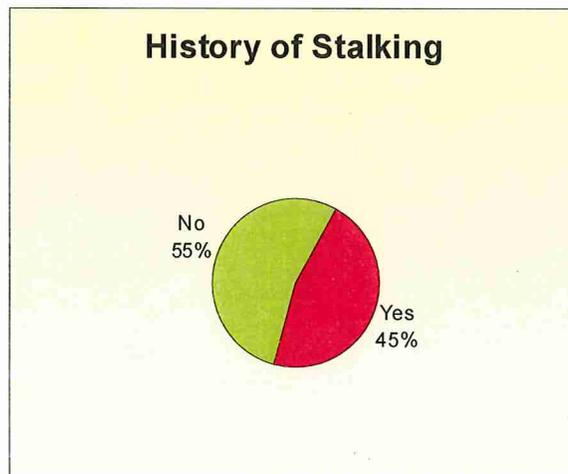
In four of these incidents, children witnessed the homicide, either visually or within earshot.

Domestic Violence History Between Perpetrator and Decedent

Thirty-six percent (36%) of these cases revealed at least one prior domestic violence police report. Forty-five percent (45%) revealed prior domestic violence reports to friends and/or family members.

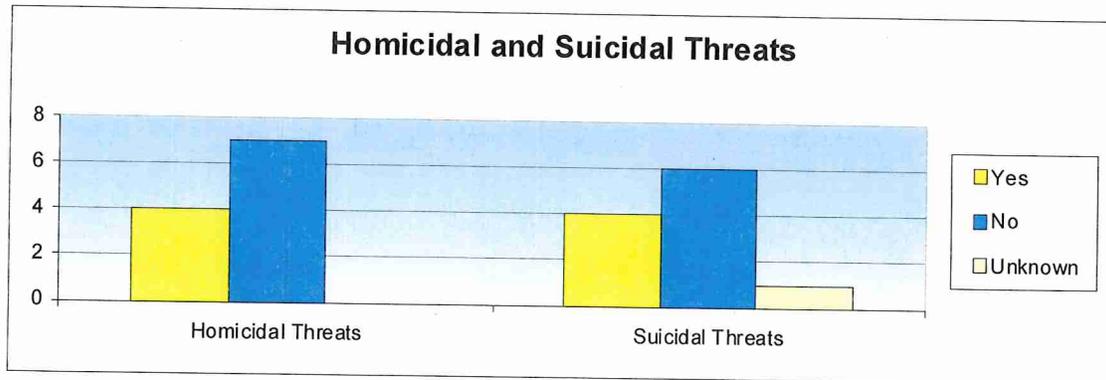
History of Stalking by Perpetrator

Forty-five percent (45%) revealed a history of stalking by the perpetrator.



Presence of Death Threats and/or Suicidal Threats

In 4 out of the 11 cases the decedent alleged that the perpetrator made homicidal threats. In 36% of the cases, the perpetrator made suicidal threats.



Criminal History of Perpetrator

Of the 11 cases reviewed:

- Three perpetrators (27%) had a domestic violence criminal history.
- Six perpetrators (55%) had a criminal record, which did not include domestic violence offenses.
- Of the three perpetrators that had a domestic violence criminal record, none were referred to a batterers' intervention program.

Injunction Actions

Three decedents (27%) had sought an Injunction for Protection against Domestic Violence against the perpetrator prior to the fatal incident.

Shelter Services

Two decedents (18%) had shelter involvement with a local domestic violence center.

DCF Involvement

Out of the 11 cases, five (45%) had some involvement in the Protective Services Division of the Department of Children and Families.

B. FEMALE PERPETRATORS

The following are our findings from the review of the 10 cases involving FEMALE perpetrators of intimate partner killings:

Length of Relationship

Of the 10 cases reviewed, five involved parties that were in a relationship for over two years, and five involved parties that were in a relationship for two years or less.

Cohabitation

In three of these cases, the decedent and perpetrator were living together at the time of the fatal incident.

Separation Between Parties

In four of the 10 cases, the decedent and the perpetrator were separated for less than six months.

Age of Decedent

Of the 10 cases, four of the decedents were between the ages of 18-29, four were between the ages of 30-39, one was between the ages of 40-49, and one decedent was between the ages of 80-89.

Race and Ethnicity of Decedent

In five of the 10 cases, the decedent was white. Five of the decedents were of Hispanic origin, one was Anglo-American, one was non-Hispanic Caribbean, one was African-American, and the other two were of unknown ethnicities.

Employment Status of Decedent

Out of the 10 decedents, six were employed at the time of the fatal incident.

Age of Perpetrator

Out of the 10 perpetrators, six were between the ages of 18-29, one was between the ages of 30-39, two were between the ages of 40-49, and one was between the ages of 80-89.

Race and Ethnicity of Perpetrator

In six of the 10 cases, the perpetrator was white. Three of the perpetrators were of Latino background, two were Anglo-American, one was non-Hispanic Caribbean, one was African-American, one was of other ethnicity (Brazilian), and the other two were of unknown ethnicities.

Employment Status of Perpetrator

Out of the 10 perpetrators, six perpetrators were employed, two were unemployed, and the employment history for two were undetermined.

Cause and Place of Death

Six of these deaths were caused by gunshot wounds and four were caused by knife wound. One death was caused in a street intersection, five at the decedent's residence, two at another residence, one in a vehicle, and the other at the decedent's workplace.¹⁸

Toxicology Findings of Perpetrators who Committed Suicide

One of the female perpetrators committed suicide, and she was under the influence of alcohol at the time of the fatal incident.

Witnessing of Fatal Incident By Children

No children witnessed these homicides.

Domestic Violence History Between Parties

In six of these cases, there were prior police reports where the *perpetrator* was the victim of domestic violence and the subject in these reports was the decedent. In two cases, there was a prior report to police alleging domestic violence by perpetrator against decedent.

In six of these cases, there were prior reports to family and/or friends that the alleging the *perpetrator* was a victim of domestic violence by decedent. There were no cases where the decedent reported to family and/or friends that he was a victim of domestic violence by Perpetrator.

In six of these cases the *perpetrator* had prior injuries caused by the decedent. In two of these cases, the *decedent* had prior injuries caused by the perpetrator.

Criminal History of Decedent and Perpetrator

In four of these cases, the *decedent* had a domestic violence criminal record, and six had a non-domestic violence criminal record. In four of these cases, the *perpetrator* had a domestic violence criminal record, and five had a non-domestic violence criminal record.

Shelter Services and Injunction Actions

Neither the perpetrators nor the decedents sought out an Injunction for Protection against Domestic Violence, or a domestic violence shelter, in any of these cases.

DCF Involvement

There were three cases that had involvement with the Department of Children and Families.

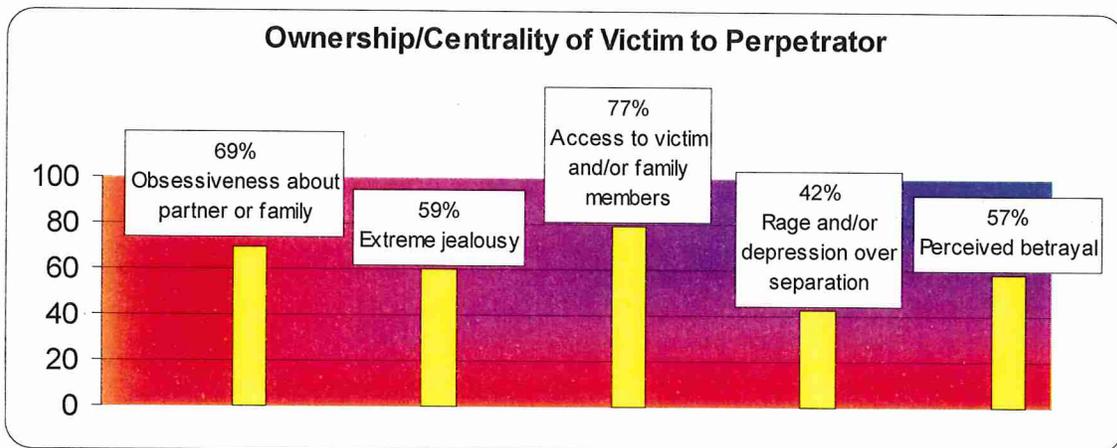
¹⁸ This was the workplace of the perpetrator as well.

C. LETHALITY INDICATORS

The following diagrams illustrate the lethality indicators for intimate partner homicide. Research has shown that these factors are salient when assessing risk of lethality. Michael Lindsay, the past Co-Chair of the Review Team, was responsible for developing and incorporating these indicators into the review process. These indicators were examined for the cases involving male perpetrators. They are Ownership/Centrality of Victim to Perpetrator, Antisocial Behavior, Decompensation, Failure of Community Control, and Severity of Violence. The lethality indicators are meant to be measured by assessing the *perpetrator's* behavior prior to the fatal incident.

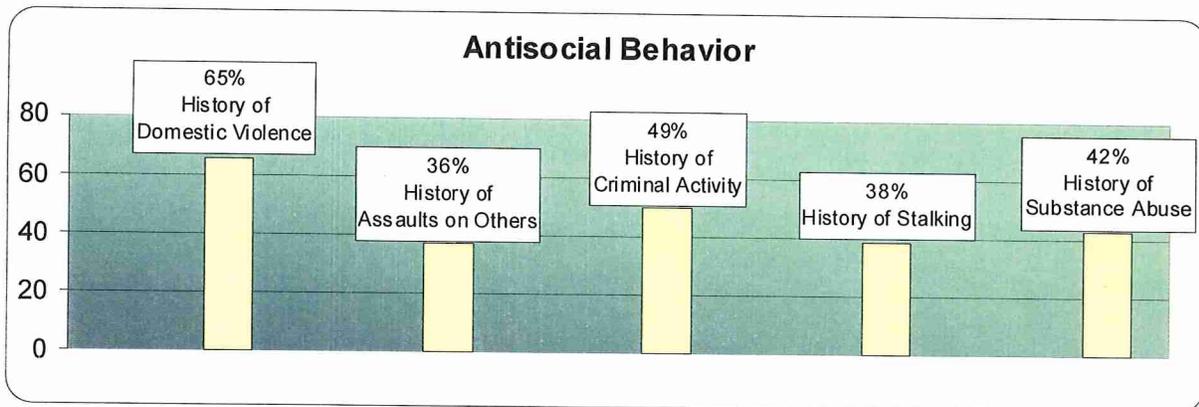
Ownership/Centrality of Victim to Perpetrator

As can be seen from the data, "Ownership/Centrality of Victim to Perpetrator" was the most prevalent lethality indicator. This indicator measures a predatory personality pattern of the perpetrator, compounded by morbid jealousy and unrelenting obsessive possessiveness of the victim. Although "History of Stalking" is measured by another lethality indicator, stalking is a form of predatory-like behavior, which clearly implies obsession toward the victim. This pattern, when coupled with other factors, suggests a high level of risk. These factors were measured by evaluating and interpreting police reports of witness statements taken after the fatal incident and/or prior incident reports made by the victim, if applicable.



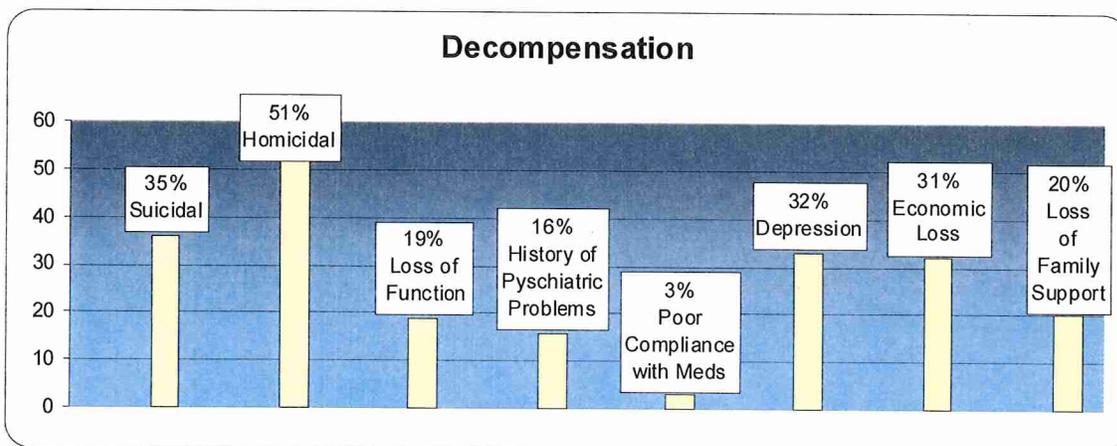
Antisocial Behavior

“Antisocial Behavior” was the second most prevalent indicator and examines history relating to antisocial tendencies. The data revealed that the majority of perpetrators had a history of domestic violence with either the victim or in a past relationship. More than one-third of the perpetrators had a history of stalking, a history of assaults on others, and/or a history of substance abuse. In a substantial portion of the cases, history of stalking and substance abuse were undetermined. Additionally, nearly half of the perpetrators had a history of some type of criminal activity.



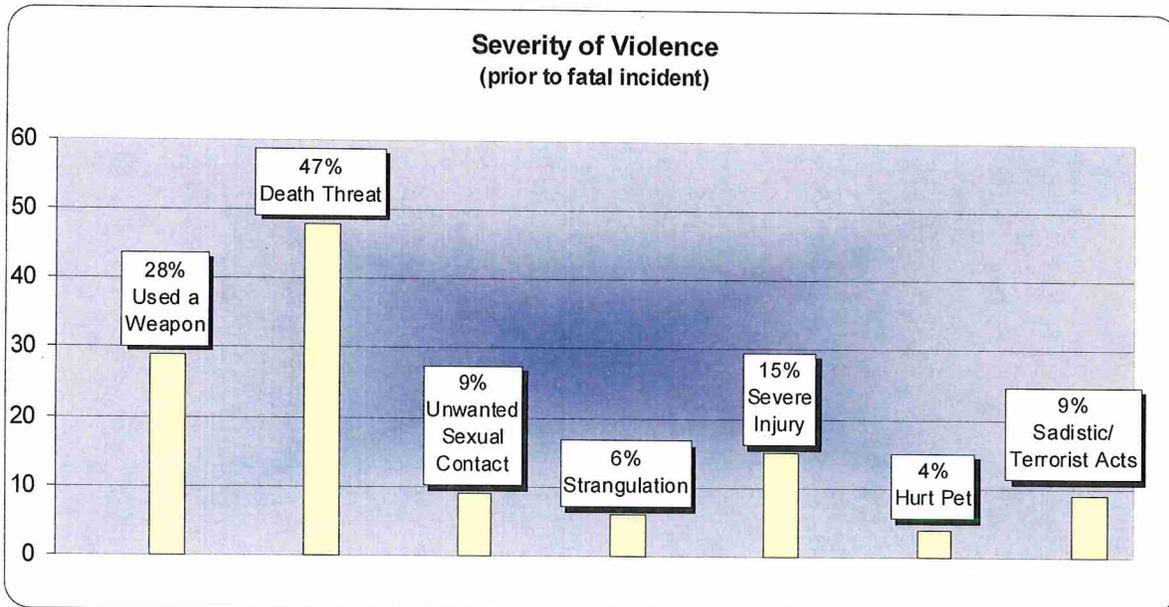
Decompensation

Decompensation, the third most prevalent of the lethality indicators, measures suicidal and homicidal ideation, several factors relating to loss, diagnosed psychiatric problems, and reported symptoms of depression. “Loss of Function” considers changes in eating and/or sleeping habits and work-related problems. One finding made is that a high percentage of perpetrators evidenced suicidal and/or homicidal thought, and verbalize these threats prior to the fatal incident. Additionally, the Review Team found that male perpetrators of multiple killings are more likely to verbalize suicidal ideations than those of single killings. Although only 16% demonstrated a history of psychiatric problems, the majority of the information relating to mental health history was unknown.



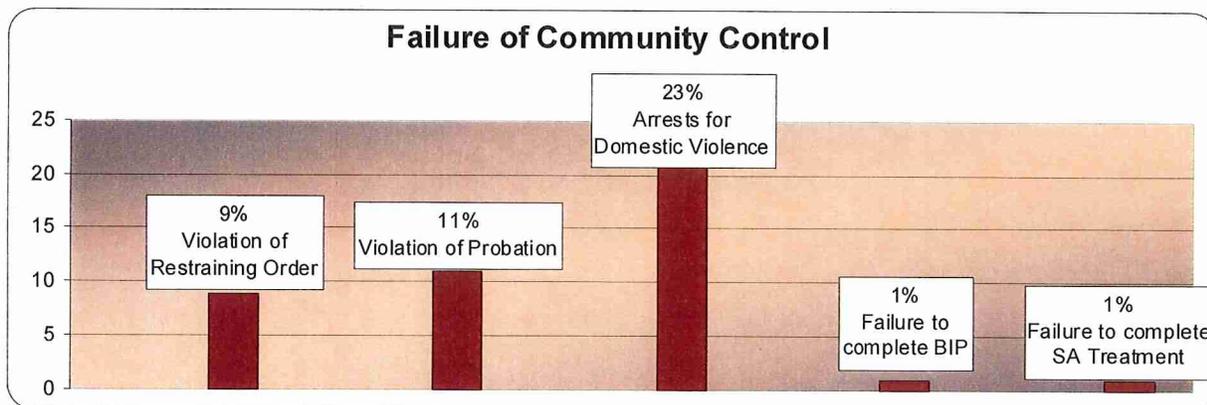
Severity of Violence

This lethality indicator measures forms of domestic violence evidenced by the perpetrator, prior to the fatal incident. These violence-related factors may have been carried out either to the decedent involved and/or to past victims of domestic violence. Research suggests that some of these factors may be even more prevalent due to underreporting. Specifically, “Unwanted Sexual Contact”, “Strangulation”, “Hurt Pet”, and “Sadistic/Terrorist Acts,” are typically not explored when conducting a homicide investigation, possibly because they are thought not to be relevant to the current homicide. However, these factors are important when assessing the level of premeditation of the perpetrator and can be used to convict the perpetrator of First-Degree Murder.



Failure of Community Control

For those perpetrators that were involved in the criminal justice system, almost a quarter had criminal histories that included arrest(s) for domestic violence. Furthermore, of those perpetrators that were subjects of Injunctions for Protection against Domestic Violence, nine percent were in violation of the restraining order.



II. FAMILY-RELATED HOMICIDE

The total number of family-related homicide cases reviewed is five. Of these cases, one involved a female perpetrator. Moreover, two of the cases involved multiple decedents.

The result of these homicide cases was as follows: two resulted in arrests, two were deemed justifiable homicide, and in one case the perpetrator committed suicide. From these cases, the following was revealed:

- One arrest was the result of parricide, or the killing of one's parents, and the perpetrator received a sentence of 50 years in state prison.
- One arrest was the result of the homicide of the perpetrator's brother-in-law. The perpetrator was convicted of Second-Degree Murder and sentenced to 10 years in state prison.¹⁹
- One of the cases that was ruled a justifiable homicide involved a female perpetrator that killed her mother's boyfriend.²⁰
- One of the cases that was ruled a justifiable homicide involved a male perpetrator who killed his brother in self-defense.
- The case involving the perpetrator that committed suicide was a multiple killing, where the perpetrator was the mother and the decedents were her three children.

In addition, the following information was ascertained:

- In 75% of these cases, the parties were living together at the time of the fatal incident.
- Perpetrators in these cases were between the ages of 30-39.
- Sixty percent (60%) of the perpetrators were white, 20% were black, and 20% of perpetrator's race was undetermined.
- Sixty percent (60%) of the perpetrators were of Latino origin, and 40% of the perpetrator's ethnicities were undetermined.
- Sixty percent (60%) of the perpetrators had less than a high school education, 20% graduated college, and 20% of the perpetrators' education level was unknown.
- Sixty percent (60%) of the perpetrators were employed and 40% were unemployed.
- Sixty percent (60%) of the perpetrators had a reported substance abuse history, and in 40% of the cases the history of substance abuse was unknown.
- Twenty percent (20%) of the perpetrators had a diagnosis or treatment for mental health illness, 20% did not, and in 60% of the cases, this information was unknown.
- Fifty percent (50%) of the homicides were a result of gunshot wounds, 37% were a result of smoke inhalation, and 13% were a result of knife wounds.
- Fifty percent (50%) of the homicides occurred at the decedent's own residence and 50% occurred at another residence.
- In the case where the perpetrator committed suicide, there was no presence of alcohol or drugs in the toxicology examination.
- The toxicology examination of one of the *decedents* revealed the presence of both alcohol and drugs.
- In one of the five *incidents*, children witnessed the homicide, either visually or by earshot.
- In one of the five cases, the decedent alleged that the perpetrator made death threats against the decedent prior to the fatal incident.
- In one of the five cases, the perpetrator had a prior domestic violence-related criminal history, and two of these cases involved perpetrators that had histories of non-domestic violence-related crimes.

¹⁹ For this case there was a history of domestic violence between the decedent and the perpetrator's sister.

²⁰ For this case there was a history of domestic violence between the decedent and the perpetrator's mother.

III. SEXUAL COMPETITOR HOMICIDE

There were two cases involving sexual competitor homicides, both of which were single killings resulting in arrests. The following information was gathered regarding these incidents:

- In one case, the perpetrator was found to have acted in self-defense.
- In one case, the perpetrator pled guilty to Second-Degree Murder.
- Of the two perpetrators, one was between the ages of 19-29, and one was between the ages 40-49.
- Of the two perpetrators, both perpetrators were black.
- Of the two perpetrators, one was of Latino origin.
- Of the two perpetrators, one was employed and one was unemployed.
- Both homicides were a result of a gunshot wound.
- Both of these incidents occurred at another residence.
- Children witnessed one incident, either visually or by earshot.
- There were no allegations of death threats in either of these two incidents.
- Of the two perpetrators, one had a non-domestic violence-related criminal history.
- The perpetrators' mental health, substance abuse, and educational background were unknown for both of these cases.

MIAMI-DADE COUNTY DOMESTIC VIOLENCE
FATALITY REVIEW TEAM

SECTION 5

MIAMI-DADE COUNTY DOMESTIC VIOLENCE

FATALITY REVIEW TEAM

FINDINGS AND RECOMMENDATIONS

Prior sections of this report have focused on quantitative findings revealed by the fatality review process. This section of the report is intended to convey qualitative findings that have emerged from the systematic review of each case. These core findings and recommendations serve to bring forth integral areas in terms of prevention, through identifying and closing system “gaps” and creating a “seamless” system. It is envisioned that these recommendations will be considered by the Advisory Panel, whose purpose is instrumental to facilitating support and access to achieving the development of prevention strategies.

Gun Violence

The Review Team found that gunshot wounds were the cause of death for the majority of domestic homicides. In addition, although surrender of firearms may be ordered as a condition of an injunction, surrender may never take place because possession may be denied. In some cases, the fatal incident occurred on the day surrender of the firearm was to take place.

A 2001 article reported that a study completed by the US Department of Justice showed an association between the decrease in gun availability and the national decrease of domestic homicide.²¹ However, this campaign appears to have had a greater impact in decreasing the number of female perpetrators that killed their abusive partners, rather than decreasing the number of male perpetrators that killed their female victims.

Further, an article, published by the Join Together project of the Boston University School of Public Health²² reported on the ability of domestic abusers to buy guns. The article reported that a congressional study found that “people with domestic-violence convictions were able to buy firearms between 1998 and 2001, because the FBI was unable to complete background checks before the sales went through.” Reports showed that the FBI has a three-day limit to complete the background check, and if not completed within this timeframe, the final sale is still done. In addition, the article stated, “the system falters when identifying misdemeanor domestic-abuse convictions or findings of mental illness because they are usually recorded on paper, and require extensive research to locate.” Currently, the standard issuance of a firearm at the time of purchase allows for a depressed, homicidal/suicidal person to legally purchase a firearm when they have not been “declared mentally incompetent” or “institutionalized for mental illness.” Additionally, gun dealers and pawn shops are not required by law to report the denial of sales of firearms as a result of identifying previous criminal or injunction history involving the buyer. The finding that guns are the most prevalent weapon used to commission domestic fatalities indicates that laws which allow for adequate time to perform background checks, such as the 30-day waiting period that the General Accounting Office suggests, should be supported.

²¹ Los Angeles Times, October 29, 2001.

²² “Domestic Abusers Able to Buy Guns,” June 26, 2002. www.jointogether.org.

Public Awareness

Our findings indicate that in the vast majority of these cases, allegations of domestic violence were made to family and/or friends. Further, many of the perpetrators had verbalized homicidal and/or suicidal ideations. When this occurred, safety measures were not put into effect. That is, when a perpetrator expressed suicidal and/or homicidal thoughts, police were not called and Baker Act proceedings were not initiated. As often is the case, friends and family minimized the level of risk posed by the perpetrator. When these types of issues arose in the past, friends and/or family called the police, but the victim denied any allegations and continued on with the relationship. This may have led to the family feeling helpless and frustrated with the situation. Unfortunately, it is not possible to determine whether a perpetrator will follow-up with threats made, however, family and friends should be offered counseling and education so that they may recognize risk factors. In addition, they should be educated on the cycle of the “battered woman” so that they can better understand and verbalize the victim’s needs. The reviews also revealed that public awareness campaigns that target cultural differences and the dynamics of domestic violence would be beneficial to victims and the community as a whole.

In many cases several entities, such as family, friends, neighbors, employers and/or co-workers, law enforcement, and other county/state agencies had some knowledge of the abuse. However, there was an under-utilization of agencies that could intervene, such as injunction and shelter services. Again, this suggests that many are either not aware of the services or choose not to utilize them. Victims need further information about the availability of assistance and should be encouraged by family and friends to access these support services. Transportation, housing, and childcare are extremely significant in facilitating access to services. Consequently, public awareness campaigns should bring these resources to the attention of the community and possibly target specific populations, such as immigrant communities, in the form of public service announcements.

Educational awareness of death threats should be a training topic to focus upon throughout the community, as well as service providers. Other areas of concern that are in need of public awareness are issues concerning elder abuse. The reviews revealed that there should be educational awareness to family members of individuals diagnosed with organic brain syndrome or other similar diseases, regarding the possibility of violent and paranoid symptomology. Additionally, family members should be given resources and taught coping techniques to help them respond to violent incidents. Further, the reviews revealed that public awareness regarding the Victims Compensation Program, which arranges financial and other assistance to survivors, may be beneficial to the community as well as treatment providers and law enforcement.

The Advocate Center for Training and Treatment initiated a public awareness campaign, “Silence isn’t Golden Anymore: Tell Somebody”, which was inspired by one of the Review Team’s initial findings, that in most of these cases someone was aware of the existence of domestic violence, but did not intervene. Our findings suggest that a public awareness campaign revealing lethality indicators and risk factors, as well as services available to the public, is paramount. This effort should be an ongoing commitment so that new services and updated research findings are communicated throughout the community.

Several fatal incidents occurred in public spaces, such as the workplace, signaling a key intervention site. The reviews revealed that employers should provide educational training to both potential victims and batterers identified by behavior displayed in the work setting. Employees should receive ongoing training regarding violence at the workplace that includes recognizing signs of domestic violence, identifying risk factors, safety planning, and behavior modification techniques. Further, employees who repeatedly exhibit violent and threatening behaviors in the workplace should be subjected to progressively stricter sanctions, beyond that of letters of warning.

Safety Planning for Victims

The reviews revealed that risk management practices (assessment and communication) of all involved agencies have not been institutionalized to the extent necessary to provide for victim safety. A clear finding is that separation increases risk for domestic homicide, and that in particular, those in the first six months of separation are at the highest risk. Results of this study indicated that in a substantial portion of the cases the decedent had separated from the perpetrator. In those cases that did not reveal separation, a vast amount had evidenced some intent or desire to leave, signaling a critical time for the victim. The obtaining of an injunction by the victim may be viewed in isolation as providing for the safety of the victim. However, the potential of heightened risk of dangerousness upon separation from the abusive relationship should be recognized. The effect of an injunction and divorce being sought by the victim may also be aggravating factors, which can result in an escalation of violence, and thus safety planning is critical. In conjunction with no contact provisions with the victim, when ruling on timesharing and child access issues, courts should consider the perpetrator's level of compliance with court orders and referrals for evaluation and treatment (i.e., BIPs, mental health, substance abuse, etc.) and hold the perpetrator accountable via monitoring compliance or lack thereof.

The reviews revealed that it would be beneficial to have community advocates provide court accompaniment for victims at injunction hearings for support, and to ensure that victims do not voluntarily dismiss petitions out of fear and/or coercion from the abusers. Additionally, the review revealed that it is essential for advocates and law enforcement to provide victims with information as to the limitations of interagency communication, in order for victims to understand their responsibility in giving information to law enforcement when there is an ongoing domestic violence criminal investigation.

Domestic Violence-Related Suicide and Other Lethality Indicators

Although traditionally not viewed as a form of domestic violence, professionals should recognize the impact of suicide on the family, particularly when the family has a history of domestic violence. Many view this as the final and most damaging form of abuse that the perpetrator inflicts on the victim. In addition, as professionals continue to try and assess risk with respect to domestic violence, they should recognize that when offenders make suicidal threats, there is a heightened risk for the victims. Clear suicidal warning signs may be present, but no homicidal threats. Professionals, family and friends should take suicidal threats seriously, particularly when the offender fits the obsessive and extremely jealous personality pattern. This pattern, when coupled with suicidal threats, increases risk of homicide dramatically. Because of this heightened risk, professionals that become aware of suicidal threats should report them to potential victims immediately and rely on their duty to warn obligation when a history of domestic violence is evident. All professionals that work in the domestic violence field should be trained to recognize and respond to suicidal threats by offenders and should take appropriate steps ensuring victim safety.

In many of the cases reviewed, the most prevalent lethality indicators were those that demonstrated an obsession and feeling of ownership of the victim, and in many cases perceived betrayal. Neil Websdale wrote,

“The term ‘betrayal’ [refers] to the abuser’s sense that his female partner has committed certain acts tantamount to emotional treachery. These acts involve more than calling the police to the scene of a domestic dispute, even though the man may see treachery in such action. Perpetrators who feel betrayed seem to experience a particularly acute sense of rejection that appears to transcend the obsessive-possessive desire to hold on to a partner.”²³

²³ Websdale, Neil. 1999. *Understanding Domestic Homicide*. Boston: Northeastern University Press.

The victims in the majority of cases that were reviewed had a negligible injunction history, history of injuries due to violent acts, and history of shelter services. Although a history of domestic violence was evident in most cases, a more manipulative and subtle form of violence characterized the abuse in many of these cases. One theory that emerges is that victims who are subject to a more overt, physical type of abuse may be easier to identify and consequently become engaged in the "system". This suggests that there remains a need for family, friends and all professionals to be educated and trained in the different forms of domestic abuse and types of domestic violence perpetrators, to better identify cases with more subtle signs of domestic violence.

Other lethality indicators that were present in the cases reviewed were antisocial behavior by the perpetrator, as well as a failure of community control. Additionally, loss of perpetrator's job, financial security, and family support are factors that may result in perpetrator's depressed state and isolation, all of which were prevalent lethality indicators. Furthermore, in the majority of these cases, the perpetrator was either found to be under the influence of alcohol and/or drugs at the time of the incident, or had a substance abuse history. As of 1998, all certified batterers' intervention program providers offer concurrent substance abuse treatment. In one case reviewed, a misdemeanor domestic violence offender was not referred to substance abuse treatment because he failed to disclose his history of substance abuse during the assessment for placement in the batterers' intervention program. Collateral information from the police investigation of the offense and victim inquiry may be necessary in order to discover the need for substance abuse treatment.

Specialized Training and Cultural Issues

More than half of the cases had some sort of domestic violence-related involvement with the police department prior to the event. More than half had prior non-domestic violence-related criminal histories. A substantial portion had involvement with the Department of Children and Families. Additionally, there were cases that revealed a number of perpetrators and/or decedents with a history of mental health treatment and/or substance abuse treatment.

Evidently, the vast majority of the cases had some sort of contact with a public or private agency. Therefore, professionals should have specialized training with respect to domestic violence issues, including child abuse. Professionals should also have knowledge on how to assess for risk in a consistent and uniform manner between agencies and should know how to implement safety planning for victims. Additionally, mechanisms should be established to identify at-risk children and services that prevent future patterns of violent behavior and victimization should be implemented to assist these children and their families.

Mental health professionals should be proficient in Baker Act laws, which allow for a person to be involuntarily committed if they are gravely disabled, meaning they are unable to care for themselves. Generally, when a person is psychotic or having a psychotic episode, they qualify for involuntary commitment under this rule, even if they presently do not evidence any homicidal or suicidal ideation. The reviews revealed that the mental health system is in need of continued training in lethality indicators and risk assessment. Additionally, there is a need for resources to intensively treat high risk cases and effectively follow-up on patients after their release from a crisis center or hospital for continued treatment and medication management.

Healthcare professionals should have continual training on how to advise patients of life-altering conditions in a sensitive manner. Additionally, comprehensive support services for patients and their families should be offered following diagnosis of serious illness. The reviews recognized that elderly men, especially those that suffer from a medical condition, are at high risk for committing suicide. Further, the risk is compounded for those who feel alone and have added stressors, such as caring for a

handicapped family member. For this reason, the Review Team recommends that healthcare professionals be trained to identify these risk factors, assess for suicide and homicide, and proceed to initiate referrals for intervention. Additionally, implementing a case management practice to respond to these cases would benefit the community.

Because of the diversity of Miami-Dade County, not only should professionals be adequately trained in issues regarding domestic violence, but they should also be culturally sensitive and competent. For example, some cultures may hold certain attitudes that encourage tolerance toward domestic violence. It is important for professionals in this field to be respectful of individual beliefs while emphasizing that domestic violence is not based on ethnicity and should not be tolerated in any community or society. Additionally, special services may need to be offered to immigrant families that do not speak English, have immigration issues pending, and are financially dependent on the domestic violence perpetrator.

Other issues for consideration are that agencies dealing with survivors of domestic homicide be well equipped in providing services to grieving families and/or children. In addition, the Review Team found that the surviving family members of homicide perpetrators who commit suicide should also be viewed as victims of these tragic incidents, and be offered services accordingly. The reviews revealed the fact that the Medical Examiner's Office does not currently have staff available to provide support and social service intervention with grieving families, which would be beneficial to the community.

The Child Welfare System and the Department of Children and Families

Through the review of cases, the Review Team noted several recommendations involving the state's child welfare system. The Review Team recommends that domestic violence-specific referrals be contemplated and made by child welfare officials where appropriate in cases of domestic violence homicide where children are involved, as opposed to general family referral sources. In addition, these domestic violence-specific referrals should be made with an expedited response.

In over one-third of the intimate partner homicides reviewed, the partners were separated at the time of the fatal incident. Furthermore, in a majority of these, the parties were separated for less than six months. Therefore, in cases where families are undergoing a separation, the Review Team feels that both parties should be screened and lethality factors should be examined.

Individuals applying for financial assistance, whether cash assistance or food stamp assistance, should be screened for domestic violence and/or child abuse to determine whether they are eligible for services. In addition, expectant parents requesting financial assistance should also be referred to parenting classes.

Educational awareness on domestic violence issues is a general need in the community, for service agencies and the general public. The Review Team recommends the continual training of child welfare officials regarding domestic violence issues. Information on domestic violence laws and services should also be given to families, particularly immigrant families, in their respective language.

Law Enforcement

Over one-third of the cases reviewed had prior contact with law enforcement regarding domestic disputes. Therefore, police departments should always distribute domestic violence brochures to domestic violence victims, and the material should be kept up-to-date with new laws and information. Due to frequent contact between victims of domestic violence and law enforcement, there should be continual training of police patrol units on risk factors for lethality, including the basics of identifying stalking. Police officers should be trained to look at the underlying scenario when responding to domestic disputes (request to

remove someone from the home) to discern whether they are actually domestic violence-related and contact the DCF Abuse Hotline in accordance with Florida law when children are present at the scene of a domestic violence-related homicide or suicide. Contact with the DCF Abuse Hotline should be made regardless of whether the child is placed in temporary custody of other family members. Police officers should also *always* document incident reports regarding domestic disputes or any domestic violence-related incident and forward these reports to a certified shelter, as required by Florida Law.

Due to the presence of domestic violence in higher learning institutions, college and university campus police should also undergo training with regard to domestic violence, as part of local county law enforcement, and be required to write police reports after each incident. Pamphlets on domestic violence should be easily accessible to students as well.

One problem identified by the Review Team at the time the reviews were conducted is a lack of general communication between police departments. More communication is needed between police departments regarding domestic violence-related cases and there should be a uniform method between police departments to determine whether a case is domestic violence-related, in accordance with the definition of domestic violence pursuant to Florida law.

Investigation of misdemeanor domestic violence-related crimes is required by Florida law to the same degree as felony cases and is critical in providing for victim safety. Reviews revealed that police domestic violence units must research prior incident reports regarding parties involved in each domestic violence call. The Review Team strongly recommends that a uniform operating procedure be implemented for all municipalities to share cross jurisdictional domestic violence calls and reports by entering them in the "clearinghouse" database administered by Miami-Dade Police Department in an effort to have a central repository for this information. In addition, it is recommended that this information be shared with the State Attorney's Office if an arrest has been made.

As these reviews would not be possible without the efforts of the respective police departments, officers should recognize the critical role of their homicide investigation records. For example, the majority of the information for this report came from police reports/records. The well-written and detailed reports served to conduct this analysis. In the future, more information regarding history, access to weapons, and the legal status of a gun, would be helpful in conducting a more extensive analysis. Therefore, channeling police reports to the departments' dedicated domestic violence unit in an expedited manner is of critical importance in providing victim safety.

An integral part of handling domestic violence-related homicide cases is the role that victim advocates play by providing services that are essential to victims and surviving family members. However, the reviews revealed that the majority of law enforcement agencies do not have victim advocates assigned to their homicide units. A large reason for this absence of victim advocate is a lack of funding.

Certified Domestic Violence Centers

At the time that these cases were reviewed, there was only one certified domestic violence center in Miami-Dade County. One of the Review Team's most striking findings is that only in six of the cases reviewed victims had sought shelter services prior to the fatal incident.²⁴ Consequently, one recommendation is to initiate a public awareness campaign regarding shelter services to the community. Additionally, as police officers forward domestic violence incident reports to the shelter, well trained staff should red-flag these cases and follow-up on these families accordingly. In addition to providing

²⁴ None of the fatal incidents occurred on the shelter premises. The cases were closed and the victims were no longer receiving services.

education to the community and providers about domestic violence centers, it is also necessary to promote them as a positive experience to increase access to shelters and level of safety. Collaborations between the child welfare system and domestic violence providers are also necessary.

Domestic Violence / Child Abuse Screenings by the School System

One of the Review Team's most disturbing findings is the great number of children who are subjected to domestic homicide. In almost one-third of these cases, children witnessed the homicide either visually or by earshot. Additionally, numerous children were themselves homicide victims and many were left orphaned after one parent killed the other and then, either killed themselves or were arrested. Research suggests that children that grow up in violent homes are at a higher risk of engaging in spousal abuse than that of the general population.²⁵ Other studies have found that children who witnessed the killing of a parent were more likely to have chronic emotional and behavioral problems, and symptoms of post-traumatic stress. Other children who were orphaned as a result of the domestic homicide were also likely to develop emotional and behavioral problems, but to a lesser extent than those who have actually witnessed the fatal incident.²⁶ Consequently, as children are so greatly affected by domestic homicide, efforts should be made to engage children and teach them about issues relating to domestic violence.

The Review Team recognizes that the school system is a medium by which we can access most of these children. Therefore, school personnel should be trained to screen for domestic violence and child abuse and call the DCF Abuse Hotline when abuse is found. When certain behaviors characteristic of abuse (i.e. acting out, withdrawal, excessive school absences) are observed, further investigation by teachers and administrators should be initiated.

The Review Team recognized two important responsibilities that should be undertaken by the school system involving educational awareness and the monitoring of children. It is believed that when there is domestic violence in families, children are aware of the violence and may be most effective in encouraging victims to leave the abusive relationship. Therefore, a major finding is that domestic violence awareness should be implemented in all schools at all grade levels. Additionally, children that witness the domestic homicide of a parent, either visually or by earshot, or become orphaned as a result of the fatal incident, should be closely followed by the school to ensure provision of support services.

Recommendations to the Justice System

The Review Team found that violation of an injunction, particularly immediately after issuance, is indicative of high risk and warrants increased bond status considerations. Recognition and communication by the prosecution of risk factors is important in providing victim safety, especially for purposes of being related to the Court in considering pretrial release and setting bond.

Recommendations to the Legislature

Re-offending by perpetrators has become a critical domestic violence issue. Currently there is no batterers' intervention program in place in the jails for domestic violence offenders. The Review Team acknowledges that a mandatory batterers' intervention program while in custody is an important public safety measure that should be implemented across the state.

²⁵ Markowitz, Fred E. 2001. "Attitudes and Family Violence: Linking Intergenerational and Cultural Theories." *Journal of Family Violence* 16:205-218.

²⁶ Kaplan, Tony, Dora Black, Philippa Hyman, and Jill Knox. 2001. "Outcome of Children Seen After One Parent Killed the Other." *Clinical Child Psychology and Psychiatry* 6:9-22.

As the fatality review process continues to develop across the State of Florida, funding to provide support staff to Domestic Violence Fatality and Child Death Review Teams is essential in order for teams to carry out the intent of the State of Florida Fatality and Child Death Review Statutes (F.S. §741.316, F.S. §741.3165; F.S. §383.402; F.S. §383.412).

Community-Wide Response

A finding from the review process is that most community and criminal justice agencies are dedicated to decreasing domestic homicide and complying with statutory mandates. In fact, the Review Team finds that many of the cases reviewed are not already involved in “the system”. This is encouraging because it suggests that once victims seek out services, their chances of being victims of domestic homicide decrease. However, although the victims in these cases may not have been fully engaged in “the system,” at one point or another many had some contact with community and/or criminal justice agencies. It appears that in some of these cases, victims were not effectively served due to gaps and poor communication between agencies. Evident from the review process is that no network of communication exists between the respective agencies. These “gaps” may be a contributing factor to the number of domestic violence-related homicides each year. Consequently, this suggests that agencies should develop and maintain technology for networking and communication. Additionally, when referring victims from one agency to another, appropriate case management should include long-term follow-up. The Review Team’s monthly meetings are an example of a forum that facilitates networking and the exchange of information between these interdependent agencies.

A specific area of communication that needs improvement is between probation officers and the State Attorney’s Office. These officers should forward any relevant information obtained regarding defendants in a timely manner. Additionally, agencies providing services to offenders that are under community supervision should be in regular contact with the supervising officers, in order to corroborate and verify information given by offenders.

To improve the cooperative efforts between agencies, the Review Team recommends that improvements be made on a technological level and with regard to referral services. Failure of automated systems to provide complete and accurate criminal histories may impact the capacity for relevant decision-makers with the criminal justice system to effectively access and manage offenders. Therefore, it is necessary to use the technology available and develop an innovative system that allows the exchange of relevant information between appropriate agencies. A streamlined system to avoid the referral of victims back and forth between law enforcement and prosecution should be a priority.

Policy Changes and Agency Involvement Brought About by the Review Process

The review process has prompted systematic change through the intensive review of each domestic violence fatality case within a multi-disciplinary setting. Examples of these changes include several policies and procedures which have been instituted by multiple justice system and community agencies. One such example is the implementation of lethality assessments by MDPS and other local law enforcement agencies responding to domestic violence incidents. In these cases, the presence of a death threat is viewed as a risk factor and police respond accordingly. In addition, findings realized through the review process served as the impetus for the creation of MDPD’s Domestic Crimes Clearinghouse, instituted under the leadership of Major Michael Herrera. The Clearinghouse is a centralized database system designed to capture statistical data from domestic violence incident reports. It provides for the exchange of information among the various police agencies with Miami-Dade, Broward, and Monroe Counties. This allows for the tracking of repeat domestic violence offenders and their victims, regardless of incident location within the

tri-county area. Under the previous system, police departments did not routinely exchange this information. Our highly mobile society lends itself to situations where persons can be involved in domestic related crime incident in various jurisdictions. Today, critical information on previous incidents involving the same victim or other victims may not be accessible to a detective handling a new case.

The Review Team has also assisted in the development of public awareness of domestic violence through advertisement campaigns. As previously mentioned, ACTT's domestic violence awareness campaign: "Silence isn't Golden Anymore: Tell Someone," was inspired by one of the Review Team's most prevalent findings, that in most cases, family and/or friends were aware of domestic violence existing in the relationship.

The Review Team has also prompted changes within the local Department of Children and Families. One example is the increased training to Child Protective Investigators in the area of domestic violence. In addition, the Review Team has encouraged the Department of Children and Families and law enforcement to work together and set up formal policies and protocol when both agencies are investigating the same family.

The Review Team participated as a trainer with Domestic Violence University (DVU). This is an in-house training institute designed to train court personnel in domestic violence issues and is the first of its kind nationally. One of the Review Team's most prevalent findings was that professional and community education, and public awareness regarding lethality indicators (risk assessment), and issues involving children, continues to be a crucial necessity. In an effort to address this, a proactive approach has been initiated, whereby comprehensive training sessions on these issues, particularly with regard to assessing risk factors, have been developed and conducted in a variety of forums before an audience of multiple disciplines. Fatality Staff trained Family Court and Domestic Violence Court staff and judges as part of this initiative, as well as Certified Domestic Violence Batterers' Intervention Program (BIP) Treatment providers.

Within the Review Team's operations, several initiatives have also taken place to assist agencies investigating fatal domestic violence incidents and those servicing surviving relatives. For example, the Review Team implemented a procedure whereby all related agencies are immediately notified of all domestic violence-related fatality incidents. This allows for an expedited response to surviving family members, as well as an immediate internal review of policies and procedures by each respective agency.

Prevention

The overall objectives of the Review Team are prevention and providing a collaborative process to bridge the gaps among the court system partners and community-based social service providers, creating a seamless system. As other cities that have implemented similar programs have found, the mere fact of reviewing these deaths and providing specialized training has decreased the national incidence of domestic homicide. Sergeant Anne O'Dell, a national expert on preventing domestic homicide, conducted a cross-country study and found that establishing a community-wide task force or fatality review team that researches domestic homicide is essential in decreasing the incidence of domestic homicide. Sergeant O'Dell states that, "we now know that at least one category of homicide- domestic violence homicide- is preventable".²⁷ The following "safer cities" have decreased their domestic homicide

²⁷ O'Dell, Anne. 1996. "Domestic Violence Homicides." The Police Chief, San Diego, CA.

rate by implementing a community-wide task force on domestic violence or domestic violence fatality review team:²⁸

- San Diego, California
- Bloomington, Illinois
- Ft. Wayne, Indiana
- Quincy, Massachusetts
- Durham, North Carolina
- Pitt County, North Carolina
- Knoxville, Tennessee
- Nashville, Tennessee
- Newport News, Virginia
- Seattle, Washington
- The State of Montana

The Review Team's mission further evolved on another level since our inception. As public awareness of the Review Team has increased, there have been several cases where the Review Team was called upon to try to intercede in a "homicide in the making." In one such instance, the Review Team was contacted when a perpetrator stated in open court that he was going to immediately leave the courthouse and kill his intimate partner. The Review Team responded by mobilizing a number of agency partners to provide for the safety of the victim and put measures in place to contain the perpetrator. On another occasion, a system representative contacted the Review Team regarding an incident that had just transpired, where one of the victim's family members was kidnapped by the perpetrator, escaped, and contacted her seeking safety. The Review Team worked together with the battered women's shelter and law enforcement to intervene and provide a safety net for the victims' family.

These cases serve as documentation of our firm belief that this type of homicide is preventable. We gratefully acknowledge and thank all of the agencies that have made Fatality Review a priority and whose dedicated work has made this report possible.

²⁸ These statistics were obtained from a 2003 domestic violence presentation by Sergeant Anne O'Dell.

MIAMI-DADE COUNTY DOMESTIC VIOLENCE

FATALITY REVIEW TEAM

APPENDIX A

Miami-Dade County Domestic Violence Fatality Review Team

DATA COLLECTION INSTRUMENT

Review # _____

The content of this Data Collection Instrument is the exclusive property of Miami-Dade County's Domestic Violence Fatality Review Team and may not be reprinted without express permission there from.

A. GENERAL CASE INFORMATION

DECEDENT

1. Name: _____
2. Address: _____
City: _____ State: _____ Zip: _____
3. Gender: Male Female
4. Age: _____ 5. Race: _____
6. DOB: _____ 7. DOD: _____
8. Religion: _____
9. Ethnicity: _____
10. Immigration status: _____
11. Marital status: single married
 separated divorced widowed
12. Education level: unknown
 less than high school some college
 some high school graduated college
 graduated high school other _____
13. Employed? yes no unknown
14. Occupation: _____
15. Occupational category: N/A
 professional technician clerical
 skilled worker laborer service worker
16. Has been in military? yes no unknown
17. How discharged? honorable medical
 dishonorable unknown N/A
18. Decedent had living children?
 yes no unknown
19. If so, names, ages, and sex of children: N/A

20. Was the Perpetrator the natural parent of any of the children?: yes no unknown N/A
If yes, place an asterisk (*) next to each child
21. Diagnosis or treatment for mental health?
 yes no unknown
22. Substance abuse (alcohol/drugs) history?
 yes (type: _____) no unknown

PERPETRATOR

23. Name: _____
24. Address: _____
City: _____ State: _____ Zip: _____
25. Gender: Male Female
26. Age: _____ 27. Race: _____
28. DOB: _____ 29. DOD: _____
30. Religion: _____
31. Ethnicity: _____
32. Immigration status: _____
33. Marital status: single married
 separated divorced widowed
34. Education level: unknown
 less than high school some college
 some high school graduated college
 graduated high school other _____
35. Employed? yes no unknown
36. Occupation: _____
37. Occupational category: N/A
 professional technician clerical
 skilled worker laborer service worker
38. Has been in military? yes no unknown
39. How discharged? honorable medical
 dishonorable unknown N/A
40. Disabled? yes (nature of disability: _____)
 no unknown
41. Has been married other than to the Decedent?
 yes no unknown N/A
42. Had child(ren) in his/her custody?
 yes no unknown
43. If so, names, ages, and sex of children: N/A

44. Diagnosis or treatment for mental health?
 yes no unknown
45. Substance abuse (alcohol/drugs) history?
 yes (type: _____) no unknown

88. HIV/AIDS? yes no unknown
89. History of other illness? yes no unknown
90. Toxicology investigation? yes no
91. Toxicology findings: N/A
 alcohol drugs (type: _____)
 both none
92. Pregnant at time of death? N/A
 yes (week gestation: _____) no unknown
93. Rape kit performed/smears and swabs taken?
 yes no
94. Evidence of recent sexual activity?
 yes no unknown
95. Evidence of recent sexual trauma?
 yes no unknown
96. Type of weapon used (check all that apply):
- | | |
|---|--|
| <u>Firearm</u> | <u>Non-firearm</u> |
| <input type="checkbox"/> semi-automatic handgun | <input type="checkbox"/> knife |
| <input type="checkbox"/> automatic handgun | <input type="checkbox"/> fists/hands or feet |
| <input type="checkbox"/> nonautomatic/revolver | <input type="checkbox"/> poison |
| <input type="checkbox"/> shotgun | <input type="checkbox"/> fire |
| <input type="checkbox"/> rifle | <input type="checkbox"/> belt/strangulation |
| <input type="checkbox"/> unknown gun type | <input type="checkbox"/> hanging/suffocation |
| <input type="checkbox"/> other _____ | <input type="checkbox"/> jumping |
| | <input type="checkbox"/> moving vehicle |
| | <input type="checkbox"/> electrocution |
| | <input type="checkbox"/> drowning |
| | <input type="checkbox"/> poison by gas |
| | <input type="checkbox"/> other _____ |
97. Body part affected: head trunk
 extremities neck

C. LAW ENFORCEMENT

98. Police Case # (for homicide): _____
 Police Department: _____
99. Perpetrator/suspected Perpetrator identified?
 yes no
100. Number of Perpetrators: _____
101. Perpetrator arrested for homicide of Decedent?
 yes (Case #: _____ date: _____)
 no investigation pending N/A

102. Other victims/persons injured, excluding the Perpetrator?
 yes (who: _____)
 no unknown
103. Who owned weapon?
 Decedent Perpetrator unknown
 other _____
104. If gun: legal illegal unknown N/A
105. Was Perpetrator known to carry or possess a weapon? yes (what kind: _____)
 no unknown
106. Did child(ren) witness homicide?
 yes how: _____
 no unknown
107. If Perpetrator committed suicide, did child(ren) witness it? yes (how: _____)
 no unknown N/A

D. HISTORY OF DOMESTIC VIOLENCE BETWEEN DECEDENT AND PERPETRATOR

ALLEGATIONS BY DECEDENT

108. Prior reports to the police (including 911 calls) by Decedent alleging domestic violence by the Perpetrator? yes (how many: _____)
 no unknown
109. Other reports to family, friends, coworkers, or community by Decedent alleging domestic violence by Perpetrator?
 yes (who: _____)
 no unknown
110. Did Decedent ever experience domestic violence-related injuries received from the Perpetrator? yes no unknown
111. If yes, what type of injuries? N/A

112. Was there any known history of the Perpetrator being abusive to animals?
 yes no unknown
113. Were there any known allegations of stalking by the Perpetrator? yes no unknown

114. Did the Decedent ever allege that the Perpetrator made death threats against the Decedent prior to the event?
 yes no unknown

115. Were there any known death threats by the Perpetrator against any of his/her child(ren)?
 yes no unknown N/A

116. Were there any known prior suicide threats by the Perpetrator?
 yes no unknown

ALLEGATIONS BY PERPETRATOR

117. Prior reports to the police (including 911 calls) by the Perpetrator alleging domestic violence by the Decedent? yes (how many: _____) no unknown

118. Other reports to family, friends, coworkers, or community by Perpetrator alleging domestic violence by Decedent?
 yes (who: _____) no unknown

119. Did Perpetrator ever experience domestic violence-related injuries received from the Decedent? yes no unknown

120. If yes, what type of injuries? N/A

E. COURT HISTORY

CRIMINAL CASES (STATE ATTORNEY'S OFFICE)

PERPETRATOR'S CRIMINAL RECORD

121. At time of the event, prior domestic violence-related criminal history of Perpetrator:
[Place an asterisk (*) next to all cases where victim is same person as Decedent]

Case No.	Charge	Outcome
_____	_____	_____
_____	_____	_____
_____	_____	_____

no criminal history on record

122. Were any Stay Away Orders entered in any of the above-listed domestic violence-related cases? yes (list Case #s below) no N/A

123. At time of the event, prior criminal history of Perpetrator for non-domestic violence-related crimes:

Case No.	Charge	Outcome
_____	_____	_____
_____	_____	_____
_____	_____	_____

no criminal history on record

124. If Perpetrator was arrested for homicide of Decedent, outcome of court case: N/A

DECEDENT'S CRIMINAL RECORD

125. At time of the event, prior domestic violence-related criminal history of Decedent:
[Place an asterisk (*) next to all cases where victim is same person as Perpetrator]

Case No.	Charge	Outcome
_____	_____	_____
_____	_____	_____

no criminal history on record

126. Were any Stay Away Orders entered in any of the above-listed domestic violence-related cases? yes (list Case #s below) no N/A

127. At time of the event, prior criminal history of Decedent for non-domestic violence-related crimes:

Case No.	Charge	Outcome
_____	_____	_____
_____	_____	_____

no criminal history on record

PROBATION DEPARTMENT

128. Status of any cases on record:

no criminal history on record

INJUNCTION ACTIONS

INITIATED BY DECEDENT

- 129. Did Decedent ever file for an injunction against the Perpetrator?
 yes (Case # _____) no
- 130. If yes, was a Temporary Injunction granted?
 yes (issue date: _____ /
expiration date: _____)
 no N/A
- 131. If yes, was a Permanent Injunction granted?
 yes (issue date: _____ /
expiration date: _____)
 no N/A
- 132. Were there any allegations that the injunction was violated? yes no N/A
- 133. If there were allegations of an injunction violation, was there an arrest? N/A
 yes (see Criminal History section) no
- 134. Did the Decedent allege the Perpetrator possessed weapons? yes no N/A
- 135. Was the Perpetrator ordered to surrender any weapons? yes no N/A
- 136. Final outcome of injunction case: N/A

- 137. Did anyone other than the Decedent ever file for an injunction against the Perpetrator?
 yes (Case # _____) no
- 138. If yes, relationship to Perpetrator: N/A

- 139. If yes, final outcome of injunction case: N/A

- 140. Did Decedent ever file for an injunction against someone other than the Perpetrator?
 yes (Case # _____) no
- 141. If yes, relationship to Respondent: N/A

- 142. If yes, final outcome of injunction case: N/A

INITIATED BY PERPETRATOR

- 143. Did Perpetrator ever file for an injunction against the Decedent?
 yes (Case # _____) no
- 144. If yes, was a Temporary Injunction granted?
 yes (issue date: _____ /
expiration date: _____)
 no N/A
- 145. If yes, was a Permanent Injunction granted?
 yes (issue date: _____ /
expiration date: _____)
 no N/A
- 146. Were there any allegations that the injunction was violated? yes no N/A
- 147. If there were allegations of an injunction violation, was there an arrest? N/A
 yes (see Criminal History section) no
- 148. Did the Perpetrator allege the Decedent possessed weapons? yes no N/A
- 149. Was the Decedent ordered to surrender any weapons? yes no N/A
- 150. Final outcome of injunction case: N/A

- 151. Did anyone other than the Perpetrator ever file for an injunction against the Decedent?
 yes (Case # _____) no
- 152. If yes, relationship to Decedent: N/A

- 153. If yes, final outcome of injunction case N/A

- 154. Did Perpetrator ever file for an injunction against someone other than the Decedent?
 yes (Case # _____) no
- 155. If yes, relationship to Respondent: N/A

- 156. Final outcome of injunction case: N/A

163. Court involved with children or other family members as a result of this death?
 yes no unknown
164. Were there any juvenile records involving any of the minor child(ren) involved?
 yes (list case info below) no N/A

BATTERERS' INTERVENTION PROGRAMS

BY DECEDENT

165. Had the Decedent been ordered to attend a batterers' intervention program as the result of any court case? yes no N/A
166. If yes, case number and type of case: N/A

167. If yes, to what agency was the Decedent referred? N/A

168. If yes, how many times did the Decedent attend/miss the group sessions? N/A attended _____ missed _____ sessions

169. Did the Decedent successfully complete the program? N/A
 yes no (was revoked/terminated)
 still enrolled at time of event

170. Comments from records: N/A

- no records obtained
 records reveal no further significant comments

BY PERPETRATOR

171. Had the Perpetrator been ordered to attend a batterers' intervention program as the result of any court case? yes no N/A

172. If yes, case number and type of case: N/A

173. If yes, to what agency was the Perpetrator referred? N/A

174. If yes, how many times did the Perpetrator attend/miss the group sessions? N/A attended _____ missed _____ sessions

175. Did the Perpetrator successfully complete the program? N/A
 yes no (was revoked/terminated)
 still enrolled at time of event

176. Comments from records: N/A

- no records obtained
 records reveal no further significant comments

VICTIM SUPPORT SERVICE PROVIDERS

BY DECEDENT

177. Was there any record of the Decedent attending/utilizing any victim support services?
 yes no unknown

178. If yes, which one(s)? N/A

179. Comments from records: N/A

- no records obtained
 records reveal no further significant comments

BY PERPETRATOR

180. Was there any record of the Perpetrator attending/utilizing any victim support services?
 yes no unknown N/A

181. If yes, which one(s)? N/A

182. Comments from records: N/A

no records obtained
 records reveal no further significant comments

CHILDREN'S SERVICE PROVIDERS

183. Was there any record of the child(ren) attending/utilizing any children's services?
 yes no unknown

184. If yes, which one(s)? N/A

185. Comments from records: N/A

no records obtained
 records reveal no further significant comments

PSYCHOLOGICAL SERVICE PROVIDERS

BY DECEDENT

186. Was there any record of the Decedent attending/utilizing any psychological services?
 yes no unknown

187. If yes, which one(s)? N/A

188. If yes, was there ever a diagnosis made?
 yes (what: _____) no
 unknown N/A

189. If yes, was medication(s) prescribed?
 yes (what kind(s): _____) no
 unknown N/A

190. If yes, was Decedent known to comply with taking medication(s)?
 yes no unknown N/A

191. Comments from records: N/A

no records obtained
 records reveal no further significant comments

BY PERPETRATOR

192. Was there any record of the Perpetrator attending/utilizing any psychological services?
 yes no unknown

193. If yes, which one(s)? N/A

194. If yes, was there ever a diagnosis made?
 yes (what: _____) no
 unknown N/A
195. If yes, was medication(s) prescribed?
 yes (what kind(s): _____) no
 unknown N/A
196. If yes, was Perpetrator known to comply with taking medication(s)?
 yes no unknown N/A
197. Comments from records: N/A

- no records obtained
 records reveal no further significant comments

SUBSTANCE ABUSE SERVICE PROVIDERS

BY DECEDENT

198. Was there any record of the Decedent attending/utilizing any substance abuse services? yes no unknown
199. If yes, which one(s)? N/A

200. Comments from records: N/A

- no records obtained
 records reveal no further significant comments

BY PERPETRATOR

201. Was there any record of the Perpetrator attending/utilizing any substance abuse services? yes no unknown
202. If yes, which one(s)? N/A

203. Comments from records N/A

- no records obtained
 records reveal no further significant comments

DOMESTIC VIOLENCE SHELTER

BY DECEDENT

204. Was there any record of the Decedent at Domestic Violence Shelter? yes no
205. If yes, during what time frame? N/A

206. Comments from records: N/A

- no records obtained
 records reveal no further significant comments

BY PERPETRATOR

207. Was there any record of the Perpetrator at Domestic Violence Shelter?
 yes no N/A
208. If yes, during what time frame? N/A

209. Comments from records: N/A

- no records obtained
 records reveal no further significant comments

SCHOOL SYSTEM RESPONSE

210. Had the Perpetrator harassed, threatened, or battered the Decedent at school or on the way to school? yes no unknown N/A
211. Were school officials notified of the existence of domestic violence?
 yes no unknown N/A

212. Comments from records: N/A

- no records obtained
 records reveal no further significant comments

HEALTH CARE/MEDICAL FACILITIES

213. Did Decedent ever seek medical attention for any domestic violence-related injuries received by the Perpetrator? yes no unknown
214. If yes, what type of injuries and when? N/A

215. If yes, what medical facility did the Decedent go to for medical attention?: N/A

216. Comments from records: N/A

- no records obtained
 records reveal no further significant comments

OTHER SOCIAL SERVICE AGENCIES

217. Is there any record of the Decedent or Perpetrator accessing any other social service agencies?
Decedent: yes no unknown
Perpetrator: yes no unknown

218. Comments from records: N/A

- no records obtained
 records reveal no further significant comments

CHURCHES/SYNAGOGUES (CLERGY)

219. Is there any record of the Decedent or Perpetrator involving their church/synagogue (clergy) with any incidence of domestic violence? N/A
Decedent: yes no unknown
Perpetrator: yes no unknown
220. If yes, name and location of religious institution:

 unknown N/A
221. If yes, is there any record of a response by the clergy? N/A

G. WORKPLACE INVOLVEMENT

222. Had the Perpetrator harassed, threatened, or battered the Decedent at or on the way to the workplace? yes no unknown N/A

223. Were supervisors aware of the existence of domestic violence?
 yes no unknown N/A

224. Name and address of workplace: N/A

225. Comments from records: N/A

- no records obtained
- records reveal no further significant comments

I. INVOLVEMENT OF FAMILY/FRIENDS

226. Were family or friends aware of any prior incidents or threats of domestic violence between the Decedent and Perpetrator?
 yes no unknown

227. If yes, who (explain relationship)? N/A

228. If yes, what was their involvement? N/A

229. Were family members or friends interviewed as part of this review? yes no
 contact attempted via letter
 participation refused upon contact

J. HISTORY OF SIGNIFICANT FAMILY MEMBERS/FRIENDS

OF DECEDENT

N/A if this section is not applicable

230. Name: _____

231. Relationship: _____

232. Address: _____
City: _____ State: _____ Zip: _____

233. Gender: Male Female

234. Age: _____ 235. Race: _____

236. DOB: _____

237. Were there any prior reports to the police (including 911 calls) involving the Decedent and this family member or friend alleging domestic violence?
 yes (how many: _____)
 no unknown

238. If yes, who was the aggressor?: N/A
 Decedent the family member or friend
 both

239. Were there other reports to family, friends, coworkers, or community involving the Decedent and this family member or friend alleging domestic violence?
 yes (who: _____)
 no unknown

240. If yes, who was the aggressor?: N/A
 Decedent the family member or friend
 both

241. Were any domestic violence-related injuries ever inflicted?
 yes (what type: _____)
 no unknown

242. If yes, who was the aggressor?: N/A
 Decedent the family member or friend
 both

243. Was there any known history of the aggressor being abusive to animals? N/A
 yes no unknown
244. Were there any known allegations of stalking by the aggressor? N/A
 yes no unknown

245. Did this family member or friend have a criminal record?
 [Place an asterisk (*) next to all cases where victim is same person as Decedent]

Case No.	Charge	Outcome

no criminal history on record

246. Were any Stay Away Orders entered in any of the above-listed domestic violence-related cases? yes (list Case #s below) no N/A

247. If the person is a former spouse, provide case number of dissolution of marriage action and status of case at time of event:

N/A

248. Other relevant information:

OF PERPETRATOR

N/A if this section is not applicable

249. Name: _____

250. Relationship: _____

251. Address: _____
 City: _____ State: _____ Zip: _____

252. Gender: Male Female

253. Age: _____ 254. Race: _____

255. DOB: _____

256. Were there any prior reports to the police (including 911 calls) involving the Perpetrator and this family member or friend alleging domestic violence?
 yes (how many: _____)
 no unknown

257. If yes, who was the aggressor?: N/A
 Perpetrator the family member or friend
 both

258. Were there other reports to family, friends, coworkers, or community involving the Perpetrator and this family member or friend alleging domestic violence?
 yes (who: _____)
 no unknown

259. If yes, who was the aggressor?: N/A
 Perpetrator the family member or friend
 both

260. Were any domestic violence-related injuries every inflicted ?
 yes (what type: _____)
 no unknown

261. If yes, who was the aggressor?: N/A
 Perpetrator the family member or friend
 both

262. Was there any known history of the aggressor being abusive to animals? N/A
 yes no unknown

263. Were there any known allegations of stalking by the aggressor? N/A
 yes no unknown

264. Did this family member or friend have a criminal record?

[Place an asterisk (*) next to all cases where victim is same person as Perpetrator]

Case No.	Charge	Outcome

no criminal history on record

265. Were any Stay Away Orders entered in any of the above-listed domestic violence-related cases? yes (list Case # below) no N/A

266. If the person is a former spouse, provide case number of dissolution of marriage action and status of case at time of event:

N/A

267. Other relevant information:

K. LETHALITY INDICATORS

Decompensation

- suicidal
- homicidal
- loss of function (not eating, sleeping, working)
- history of psychiatric problems
- poor compliance with taking medication
- depression
- economic loss
- loss of family support

Ownership/Centrality of Victim to Perpetrator

- obsessiveness about partner or family
- extreme jealousy
- access to victim and/or family members
- rage and/or depression over separation
- perceived betrayal

Antisocial Behavior

- history of domestic violence
- history of assaults on others
- history of criminal activity
- history of stalking
- history of substance abuse

Failure of Community Control

- violation(s) of restraining order
- violation(s) of probation
- arrest(s) for domestic violence
- failure to complete BIP
- failure to complete substance abuse treatment

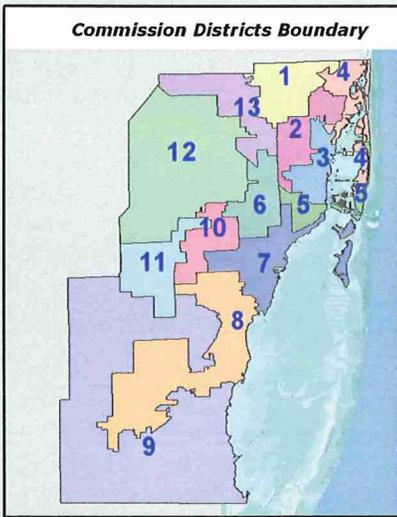
Severity of violence

- used a weapon
- death threat
- unwanted sexual contact
- strangulation
- hurt pet
- severe injury
- sadistic/terrorist acts

Other factors

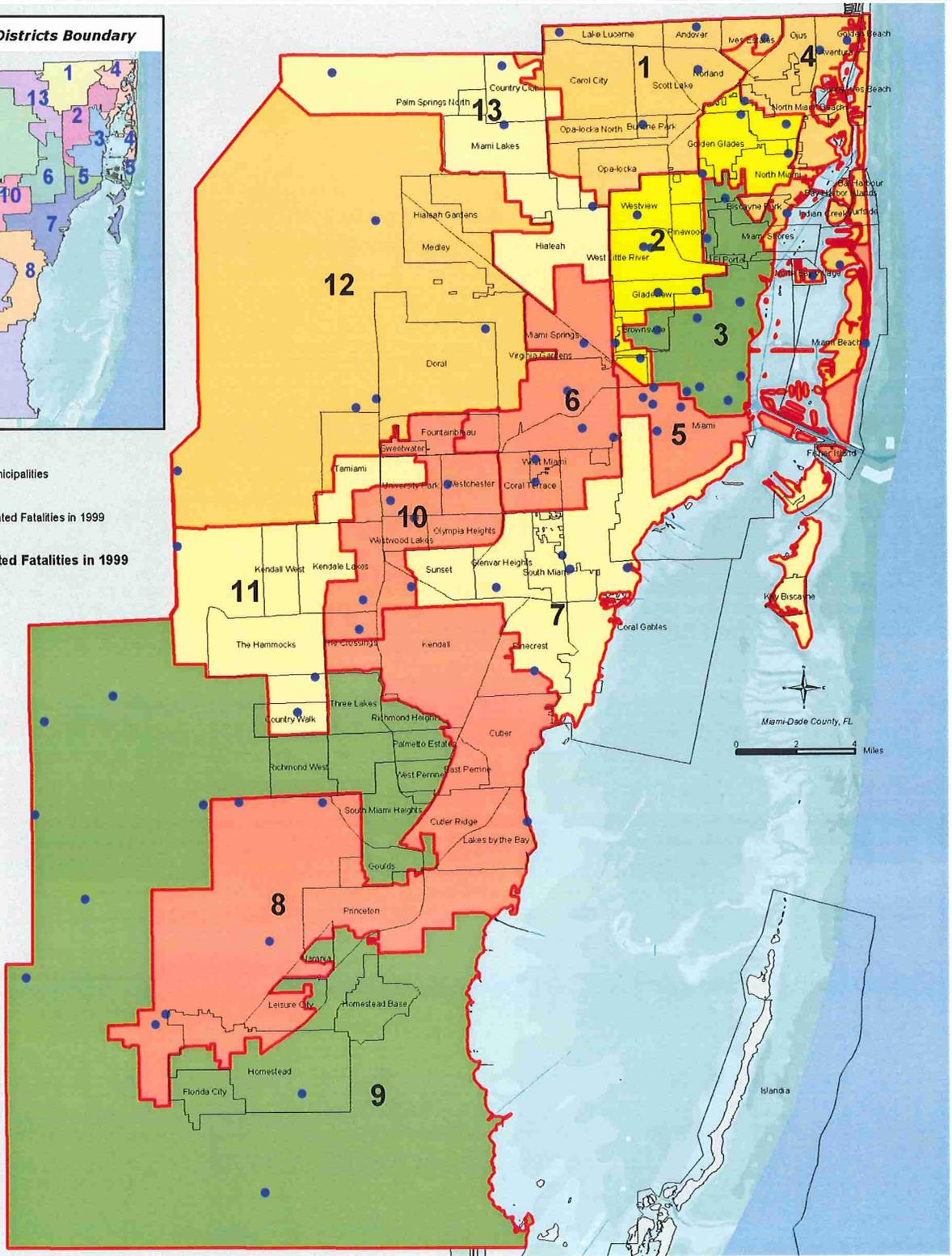
APPENDIX B

Domestic Violence-Related Fatalities (Homicides and Suicides) in 1999 (Dot Density Map)



Legend

- Census Places and Municipalities
- 1 Dot = 1
- Domestic Violence-Related Fatalities in 1999
- Commission Districts
- Domestic Violence-Related Fatalities in 1999**
- 3 - 4
- 5
- 6 - 7
- 8 - 9
- 10 - 12



Revision Date: Sept. 20th, 2002

DOT DENSITY INTERPRET USE:
The dots on the map are intended to geographically display the random distribution of deaths involving homicide(s) and/or suicide(s). The records were aggregated and plotted randomly at the Commission District level and each dot represents one(1) fatality of homicide or suicide.

CAUTIONS FOR THE USE OF THIS PRODUCT:
The points were geocoded according to the incident location of the homicide(s) and/or suicide(s) and not the residential location of the decedent(s) or perpetrator(s). The dots on the map were randomly distributed according to the number of deaths involving the homicide(s) and/or suicide(s) within the Commission District boundary and should not be used for site specific information.

DISCLAIMER:

Users must assume responsibility to determine the appropriate use of these data. All aspects of the data provided herein are susceptible to a degree of error due to the complexities of the process involved in compiling and programming the data. The Florida Department of Children and Families, or the Community Services Planning Center nor any of their employees makes no expressed or implied warranty, representation, or guaranty regarding the content, sequence, accuracy, timeliness, completeness, or the fitness of the data for a particular purpose. The materials contained herein are provided "AS IS" and may contain inaccuracies. Users are warned to utilize the material herein at their own risk and to verify the materials accuracy independently, and assumes the risk of any and all loss. Please contact the Community Services Planning Center at (305) 377-7639 for more detailed information if required.

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Florida Department of Children and Families, District 11
Community Services Planning Center
401 NW 2nd Avenue, Room 11021
Miami, Florida 33128
Phone: (305) 377-7639
Monday - Friday 9:00am to 5:00pm, Eastern Standard Time



FOR THE PURPOSE OF THIS REPORT

A death has been defined as being domestic violence-related when the relationship between the victim and the perpetrator is that of spouse, former spouse, family members (including persons related by parent or former marriage), persons presently or formerly in a romantic or intimate relationship (regardless of whether they have resided together in the present or past), or involving any significant others of persons presently or formerly in a romantic or intimate relationship.

"Child Death" means a minor child who died at the hands of a parent or caretaker and/or was reported to the Florida Department of Children and Families as possibly suspicious.

CALCULATION OF RATES

Homicide and Suicide Rate =
[(Indicator x 100,000) / Total Population US Census 2000]

Domestic Violence Related Fatalities Rate =
[(Indicator x 100,000) / Total Population US Census 2000]

Child Death Rate =
[(Indicator x 100,000) / Total Population under 18 yrs of age, US Census 2000]

Confidentiality of Child Data

The 2000 Florida Statutes, Title XXXIX Public Health Chapter 383 Section 383.410 and 383.402 - Criminal Law prohibits unauthorized access and use. Violators will be prosecuted to the fullest extent of the law.

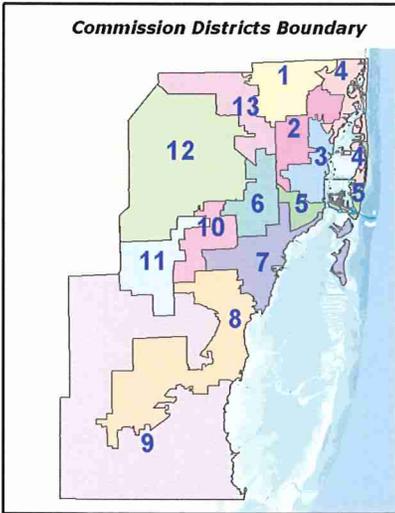
Data source:
Domestic Violence Fatality Review Team
175 NW 1st Avenue, 15th Floor
Miami, FL 33120



Commission District	Miami Dade Population Census 2000		Homicide & Suicide Deaths in 1999 (Domestic Violence and Non-Domestic Violence Related)		Domestic Violence Related Fatalities 1999 (Homicides & Suicides)		Miami Dade Population Census 2000		Child Deaths in 1999	
	Total	Rate	Number	Rate	Number	Rate	Under 18	Number	Rate	
1	168,865	57	34	20.13	5	2.96	52,391	2	3.82	
2	169,370	57	33.65	12	7.09	53,138	2	3.76		
3	169,349	92	54.33	9	5.31	46,468	3	6.46		
4	170,096	35	20.58	5	2.94	31,611	2	6.33		
5	175,626	65	37.01	6	3.42	29,270	4	13.67		
6	176,764	31	17.54	6	3.39	34,916	3	8.59		
7	175,537	29	16.52	4	2.28	34,713	1	2.88		
8	176,356	26	14.74	7	3.97	49,800	2	4.01		
9	172,297	29	16.63	8	4.64	56,451	1	1.77		
10	169,859	19	11.19	6	3.53	36,172	0	0.00		
11	179,073	13	7.26	3	1.68	48,289	0	0.00		
12	170,041	25	14.70	5	2.94	43,638	0	0.00		
13	180,109	28	15.55	4	2.22	42,376	1	2.36		
Unmatched Records			8		1			0		
Totals	2,253,362	491	21.79	81	3.59	559,213	21	3.76		

Domestic Violence-Related Fatalities (Homicides and Suicides) in 2000

(Dot Density Map)



Legend

□ Census Places and Municipalities

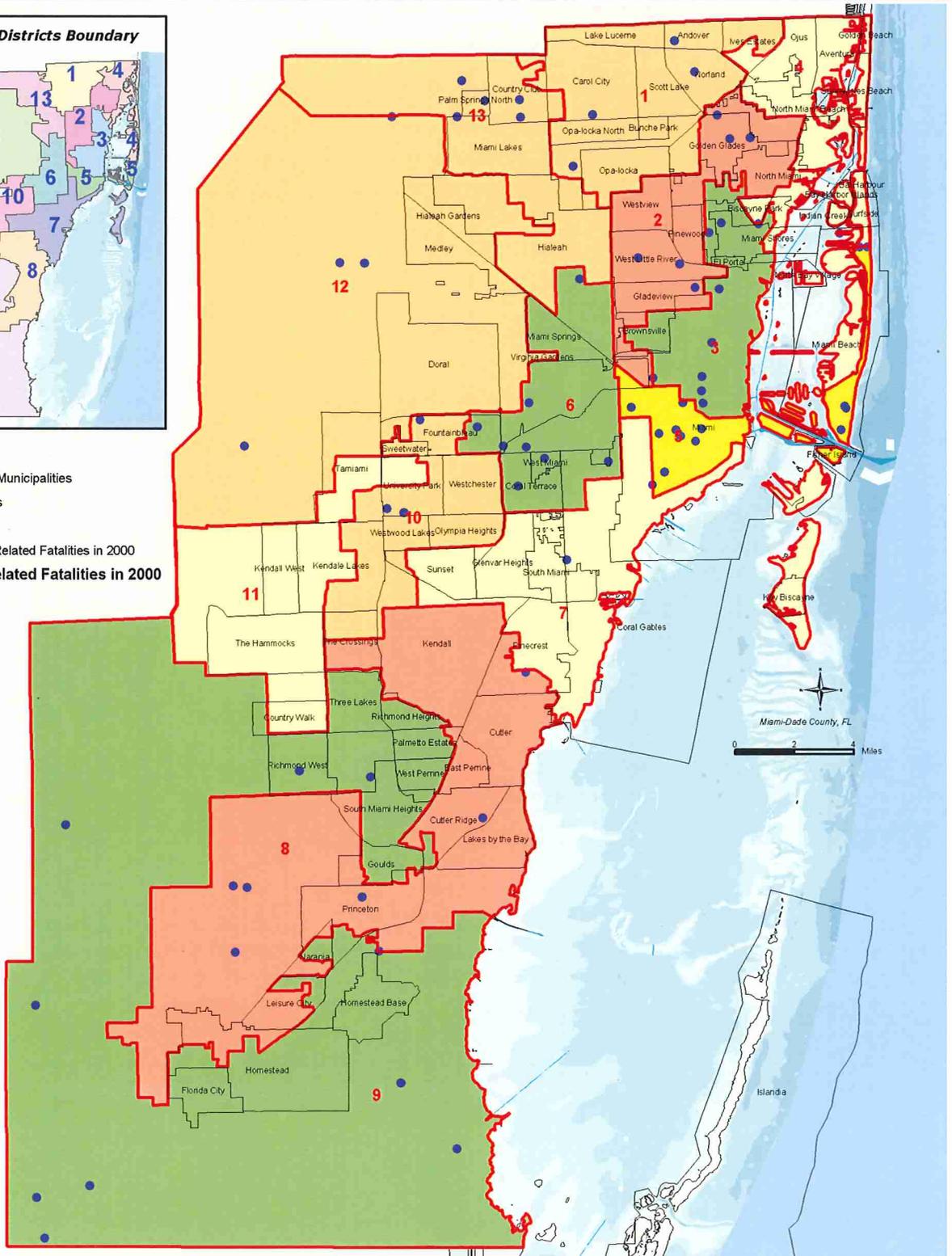
□ Commission Districts

● 1 Dot = 1

● Domestic Violence-Related Fatalities in 2000

Domestic Violence-Related Fatalities in 2000

- 0 - 1
- 2 - 5
- 6 - 7
- 8 - 9
- 10 - 14



DOT DENSITY INTENDED USE
The dots on the map are intended to geographically display the random distribution of deaths involving homicide(s) and/or suicide(s). The records were aggregated and plotted manually at the Commission District level and each dot represents one(1) fatality of a homicide or suicide.

CAUTIONS FOR THE USE OF THIS PRODUCT:
The points were geocoded according to the incident location of the homicide(s) and/or suicide(s) and not the residential location of the decedent(s) or perpetrator(s). The dots on the map were randomly distributed according to the number of deaths involving the homicide(s) and/or suicide(s) within the Commission District boundary and should not be used for site-specific information.

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Community Services Planning Center
401 NW 2nd Avenue, Room 11021
Miami, Florida 33136
Phone: (305) 377-7829
Monday - Friday 9:00am to 5:00pm, Eastern Standard Time

FOR THE PURPOSE OF THIS REPORT

"Domestic Violence" means any assault, aggravated assault, battery, aggravated battery, sexual assault, sexual battery, stalking, aggravated stalking, kidnapping, false imprisonment, or any criminal offense resulting in physical death of one adult and/or minor family or household member by another who is or was residing in the same single dwelling unit and/or one member intimately involved with another who is or was not residing in the same single dwelling unit.

"Child Death" means a minor child who died at the hands of a parent or caretaker and/or was reported to the Florida Department of Children and Families as a child in need of protection.

CALCULATION OF RATES

Homicide and Suicide Rate =
[(Indicator x 100,000) / Total Population US Census 2000]

Domestic Violence Related Fatalities Rate =
[(Indicator x 100,000) / Total Population US Census 2000]

Child Death Rate =
[(Indicator x 100,000) / Total Population under 18 yrs of age, US Census 2000]

Confidentiality of Child Data

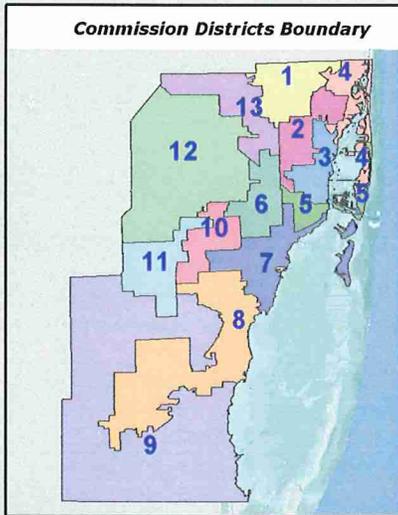
The 2000 Florida Statutes, Title XXIX Public Health Chapter 383 Section 383.410 and 383.402 - Criminal Law prohibits unauthorized access and use. Violators will be prosecuted to the fullest extent of the law.

Data source:
Domestic Violence Fatality Review Team
175 NW 1st Avenue, 15th Floor
Miami, FL 33130

Commission District	Miami Dade Population Census 2000		Homicides & Suicide Deaths in 2000 (Domestic Violence- and Non-Domestic Violence- Related)		Domestic Violence-Related Fatalities in 2000 (Homicides & Suicides)		Miami Dade Population Census 2000		Child Deaths in 2000	
	Total	Number	Rate	Number	Rate	Under 18	Number	Rate	Number	Rate
1	168,865	39	23.10	4	2.37	52,391	5	9.54		
2	169,370	47	27.75	6	3.54	53,138	8	15.06		
3	169,349	98	57.87	9	5.31	46,468	7	15.06		
4	170,096	32	18.81	1	0.59	31,611	1	3.16		
5	175,626	50	28.47	14	7.97	29,270	1	3.42		
6	176,764	31	17.54	8	4.53	34,916	2	5.73		
7	176,537	18	10.25	1	0.57	34,713	0	0.00		
8	176,366	15	8.51	7	3.97	49,880	0	0.00		
9	172,297	33	19.15	9	5.22	56,451	7	12.40		
10	169,869	19	11.19	3	1.77	36,172	0	0.00		
11	179,073	11	6.14	0	0.00	48,289	0	0.00		
12	170,041	22	12.94	4	2.35	43,538	0	0.00		
13	180,109	29	16.10	5	2.78	42,376	0	0.00		
Unmatched Records		11		1			0			
Totals	2,253,362	455	20.19	72	3.20	559,213	37	5.54		

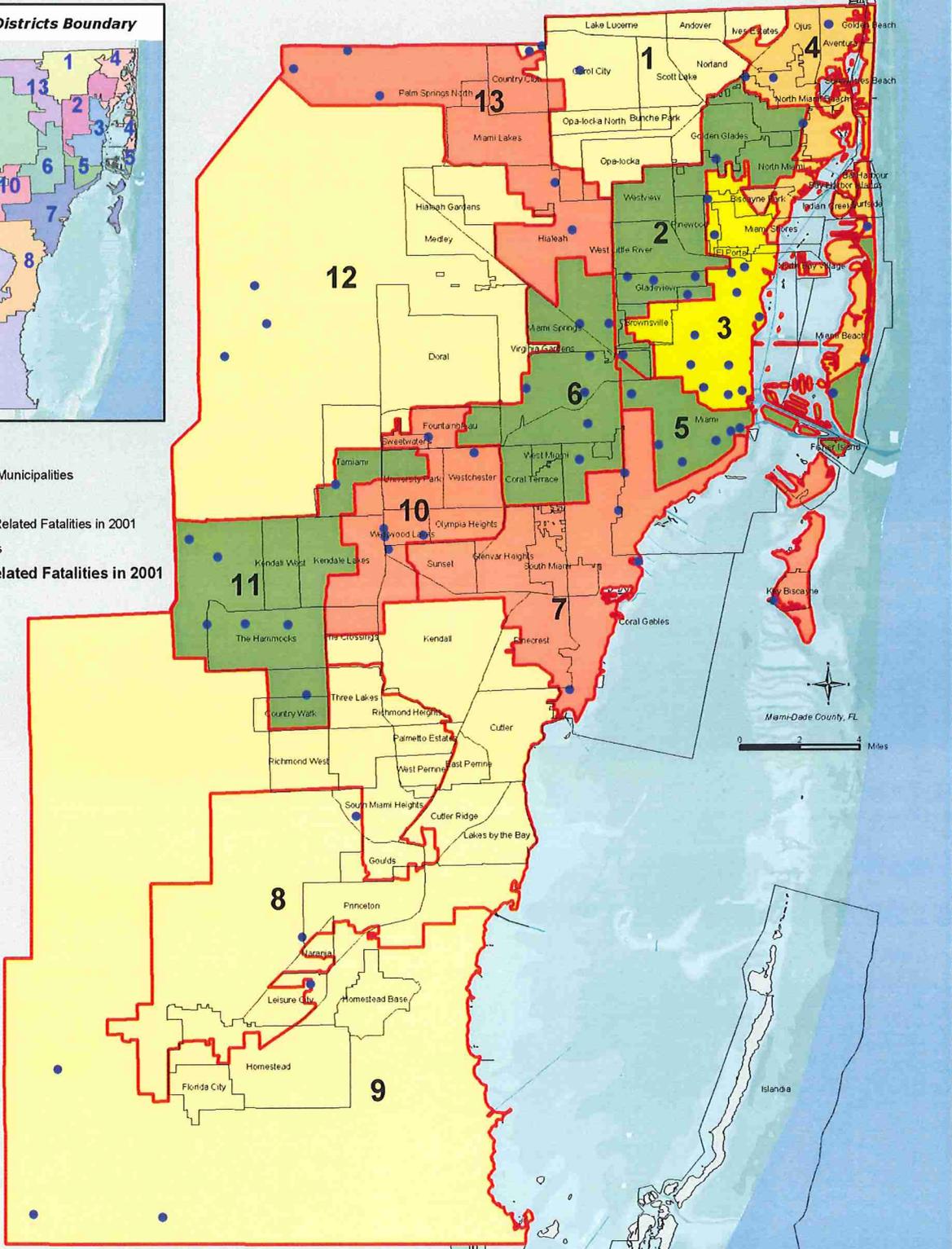


Domestic Violence-Related Fatalities (Homicides and Suicides) in 2001 (Dot Density Map)



Legend

- Census Places and Municipalities
 - 1 Dot = 1
 - Domestic Violence-Related Fatalities in 2001
 - Commission Districts
- Domestic Violence-Related Fatalities in 2001**
- 3
 - 4
 - 5-6
 - 7-8
 - 9-12



Revision Date: Sept. 24th, 2002

DOT DENSITY INTENDED USE
The dots on the map are intended to geographically display the random distribution of deaths involving homicide(s) and/or suicide(s). The records were aggregated and plotted thematically at the Commission District level and each dot represents one(1) fatality of a homicide or suicide.

CAUTIONS FOR THE USE OF THIS PRODUCT
The points were geocoded according to the incident location of the homicide(s) and/or suicide(s) and not the residential location of the decedent(s) or perpetrator(s). The dots on the map were randomly distributed according to the number of deaths involving the homicide(s) and/or suicide(s) within the Commission District boundary and should not be used for site specific information.

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FOR THE PURPOSE OF THIS REPORT
A death has been defined as being domestic violence-related when the relationship between the victim and the perpetrator is that of spouses, former spouses, family members (including persons related by blood or former marriage), persons presently or formerly in a romantic or intimate relationship (regardless of whether they have resided together in the past or past), or involving any significant others of persons presently or formerly in a romantic or intimate relationship.

Child Death means a minor child who died at the hands of a parent or caretaker and/or was reported to the Florida Department of Children and Families as initially suspicious.

CALCULATION OF RATES
Homicide and Suicide Rate = $\frac{\text{Homicide} + \text{Suicide}}{\text{Population Census 2000}} \times 100,000$
Domestic Violence Related Fatalities Rate = $\frac{\text{Domestic Violence Related Fatalities}}{\text{Population Census 2000}} \times 100,000$
Child Death Rate = $\frac{\text{Child Death}}{\text{Population Under 18 yrs of age, US Census 2000}} \times 100,000$
Confidentiality of Child Data

The 2000 Florida Statutes, Title XXIX Public Health Chapter 393 Section 393.410 and 393.402 - Criminal Law prohibits unauthorized access and use. Violators will be prosecuted to the fullest extent of the law.
Data source: Domestic Violence Fatality Review Team
175 NW 1st Avenue, 15th Floor
Miami, FL 33101

Commission District	Miami Dade Population Census 2000		Homicide & Suicide Deaths in 2001 (Domestic Violence and Non-Domestic Violence Related)		Domestic Violence-Related Fatalities in 2001 (Homicides & Suicides)		Miami Dade Population Census 2000		Child Deaths in 2001	
	Total	Rate	Number	Rate	Number	Rate	Under 18	Number	Rate	
1	168,865	42	24.87	3	1.78	52,391	4	7.63		
2	169,370	44	25.98	7	4.13	53,138	4	7.53		
3	169,349	69	40.74	12	7.09	46,468	1	2.15		
4	170,096	24	14.11	4	2.35	31,611	1	3.16		
5	175,626	38	21.64	8	4.56	29,270	3	10.25		
6	176,764	39	22.06	7	3.96	34,916	0	0.00		
7	175,537	34	19.37	6	2.85	34,713	4	11.52		
8	176,366	24	13.61	3	1.70	49,880	3	6.01		
9	172,297	30	17.41	3	1.74	56,451	2	3.54		
10	169,869	22	12.95	6	3.53	36,172	0	0.00		
11	179,073	17	9.49	7	3.91	48,269	0	0.00		
12	170,041	14	8.23	3	1.76	43,538	0	0.00		
13	180,109	18	9.99	5	2.78	42,376	1	2.36		
Unmatched Records		21		2			1			
Totals	2,253,362	436	19.35	75	3.33	559,213	24	4.29		



Domestic Violence-Related Fatalities (Homicides and Suicides) in 2002 by Incident Location (Dot Density Map)

ZIP Code	DVR2002
33010	0
33012	3
33013	0
33014	0
33015	0
33016	0
33018	0
33030	3
33031	0
33032	2
33033	1
33034	0
33035	0
33039	0
33054	4
33055	2
33056	3
33109	0
33122	0
33125	0
33126	0
33127	0
33128	0
33129	0
33130	0
33131	0
33132	0
33133	0
33134	0
33135	0
33136	2
33137	0
33138	0
33139	4
33140	1
33141	1
33142	4
33143	0
33144	2
33145	0
33146	0
33147	0
33149	0
33150	4
33154	0
33155	3
33156	0
33157	4
33158	0
33160	0
33161	3
33162	2
33165	0
33166	4
33167	2
33168	0
33169	3
33170	0
33172	1
33173	0
33174	1
33175	0
33176	1
33177	1
33178	1
33179	4
33180	0
33181	1
33182	1
33183	0
33184	0
33185	0
33186	0
33187	0
33189	2
33190	0
33192	0
33193	1
33194	0
33196	1
Unmatched	2
Total	74

Legend

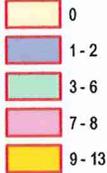
--- Census Places

• 1 Dot = 1 Death

• Domestic Violence-Related Fatalities in 2002

Commission Districts

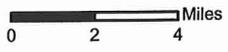
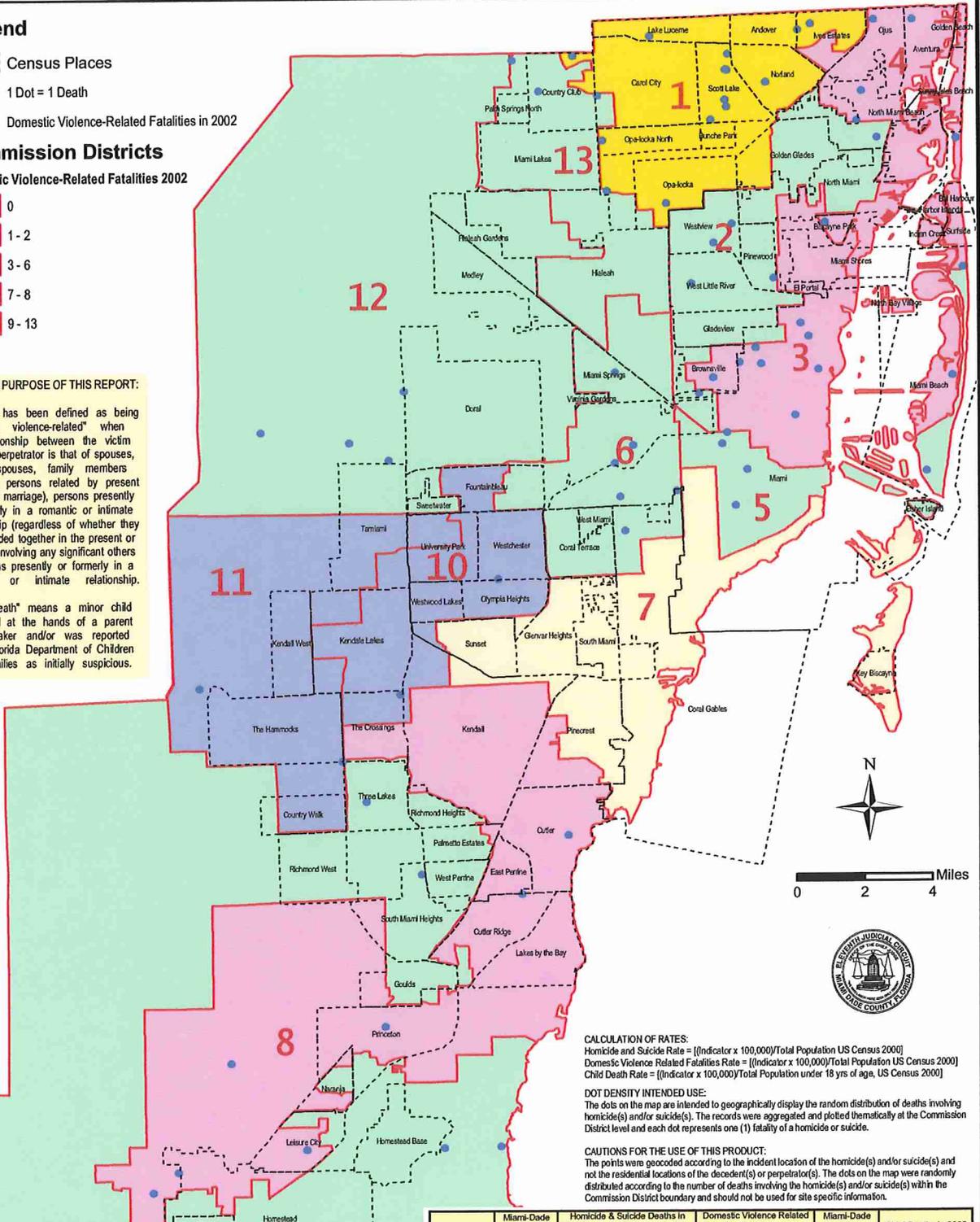
Domestic Violence-Related Fatalities 2002



FOR THE PURPOSE OF THIS REPORT:

A death has been defined as being "domestic violence-related" when the relationship between the victim and the perpetrator is that of spouses, former spouses, family members (including persons related by present or former marriage), persons presently or formerly in a romantic or intimate relationship (regardless of whether they have resided together in the present or past), or involving any significant others of persons presently or formerly in a romantic or intimate relationship.

"Child Death" means a minor child who died at the hands of a parent or caretaker and/or was reported to the Florida Department of Children and Families as initially suspicious.



Confidentiality of Child Data:

The 2000 Florida Statutes, Title XXX Public Health Chapter 383 Section 383.402 - Criminal Law prohibits unauthorized access and use. Violators will be prosecuted to the fullest extent of the law.

DISCLAIMER:

Users must assume responsibility to determine the appropriate use of these data. All aspects of the data provided herein are susceptible to a degree of error due to the complexities of the process involved in compiling and programming the data. The Florida Department of Children and Families, or the Community Services Planning Center nor any of their employees makes no expressed or implied warranty, representation, or guaranty regarding the content, sequence, accuracy, timeliness, completeness, or the fitness of the data for a particular purpose. The materials contained herein are provided "AS IS" and may contain inaccuracies. User is warned to utilize the materials herein at user's own risk and to verify the material's accuracy independently, and assumes the risk of any and all loss. Please contact the Community Services Planning Center at (305) 377-7639 for more detailed information if required.

Requests for permission to reproduce or republish any material from this map should be addressed to:

Florida Department of Children and Families, District 11
Community Services Planning Center
401 NW 2nd Avenue, Room N1021
Miami, Florida 33128
Phone: (305) 377-7639
Monday - Friday 8:00am to 5:00pm, Eastern Standard Time

CALCULATION OF RATES:

Homicide and Suicide Rate = $\frac{\text{Indicator} \times 100,000}{\text{Total Population US Census 2000}}$
Domestic Violence Related Fatalities Rate = $\frac{\text{Indicator} \times 100,000}{\text{Total Population US Census 2000}}$
Child Death Rate = $\frac{\text{Indicator} \times 100,000}{\text{Total Population under 18 yrs of age, US Census 2000}}$

DOT DENSITY INTENDED USE:

The dots on the map are intended to geographically display the random distribution of deaths involving homicide(s) and/or suicide(s). The records were aggregated and plotted thematically at the Commission District level and each dot represents one (1) fatality of a homicide or suicide.

CAUTIONS FOR THE USE OF THIS PRODUCT:

The points were geocoded according to the incident location of the homicide(s) and/or suicide(s) and not the residential locations of the decedent(s) or perpetrator(s). The dots on the map were randomly distributed according to the number of deaths involving the homicide(s) and/or suicide(s) with the Commission District boundary and should not be used for site specific information.

COMMISSION DISTRICT	Miami-Dade Population Census 2000	Homicide & Suicide Deaths in 2002 (Domestic Violence and Non-Domestic Violence Related)		Domestic Violence Related Fatalities (Homicides and Suicides)		Miami-Dade Population Under 18 Census 2000	Child Deaths in 2002	
		Number	Rate	Number	Rate		Number	Rate
1	168,865	44	26.06	13	7.70	52,391	2	3.82
2	169,370	44	25.98	6	3.54	53,138	2	3.76
3	169,349	74	43.70	8	4.72	46,468	5	10.76
4	170,096	38	22.34	8	4.70	31,611	0	-
5	175,626	56	31.89	5	2.85	29,270	2	6.83
6	176,764	25	14.14	6	3.39	34,916	1	2.86
7	175,537	23	13.10	0	-	34,713	3	8.64
8	176,366	27	15.31	8	4.54	49,880	4	8.02
9	172,297	34	19.73	6	3.48	56,451	3	5.31
10	169,869	26	15.31	2	1.18	36,172	0	-
11	179,073	12	6.70	2	1.12	48,289	0	-
12	170,041	25	14.70	4	2.35	43,538	0	-
13	180,109	28	14.44	4	2.22	42,376	0	-
Unmatched Records				2			0	
Totals	2,253,362	467	20.72	74	3.28	559,213	22	3.93

Data Source: Domestic Violence Fatality Review Team

Domestic Violence-Related Fatalities (Homicides and Suicides) in 2003 by Incident Location (Dot Density Map)

ZIP Code	DVR2003
33010	2
33012	0
33013	3
33014	0
33015	3
33016	2
33018	0
33030	0
33031	1
33032	1
33033	3
33034	0
33035	0
33039	0
33054	0
33055	3
33056	0
33109	0
33122	0
33125	0
33126	0
33127	1
33128	1
33129	0
33130	0
33131	0
33132	0
33133	1
33134	1
33135	2
33136	1
33137	0
33138	1
33139	0
33140	0
33141	2
33142	0
33143	0
33144	0
33145	0
33146	0
33147	4
33149	0
33150	1
33154	0
33155	0
33156	0
33157	1
33158	0
33160	1
33161	0
33162	2
33165	1
33166	1
33167	1
33168	0
33169	0
33170	0
33172	0
33173	0
33174	0
33175	1
33176	1
33177	5
33178	0
33179	2
33180	0
33181	0
33182	0
33183	1
33184	0
33185	1
33186	4
33187	0
33189	0
33190	0
33192	0
33193	1
33194	0
33198	1
Unmatched	0
Total	62

Legend

- Census Places
- 1 Dot = 1 Death
- Domestic Violence-Related Fatalities in 2003

Commission Districts

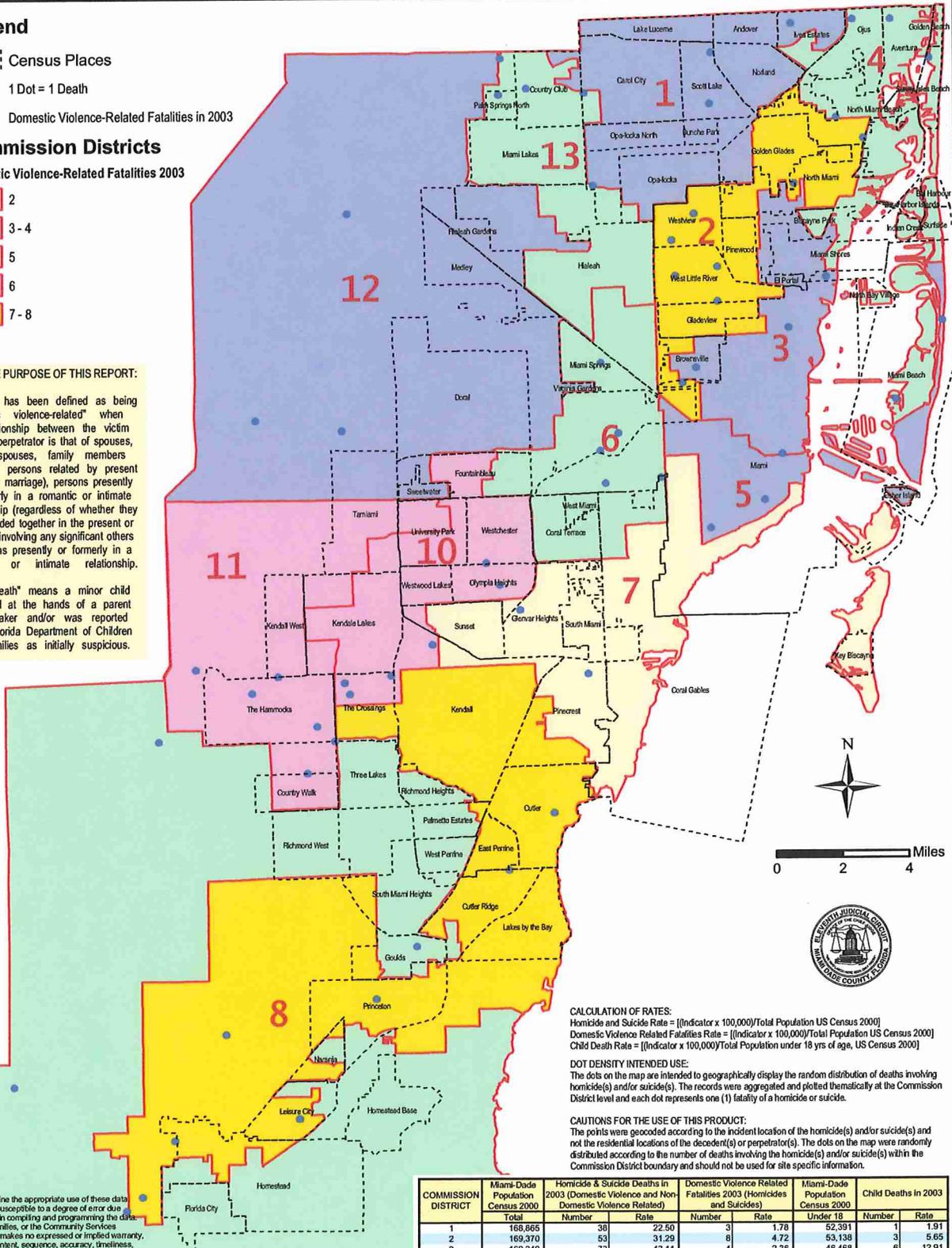
Domestic Violence-Related Fatalities 2003

- 2
- 3-4
- 5
- 6
- 7-8

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		Number	Rate	Number	Rate	Under 18	Number	Rate	
1	168,865	38	22.50	3	1.78	52,391	1	1.91	
2	169,370	53	31.29	8	4.72	53,138	3	5.65	
3	169,349	73	43.11	4	2.36	46,468	6	12.91	
4	170,096	22	12.93	4	2.94	31,811	1	3.16	
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12	170,041	19	11.17	3	1.76	43,538	0	-	
13	180,109	29	16.10	5	2.78	42,376	2	4.72	
Unmatched Records	18	0	0	0	0	5	5	0	
Totals	2,253,362	429	19.04	62	2.75	659,213	27	4.83	

Data Source: Domestic Violence Fatality Review Team

